DIGNITY AND THE LEGAL JUSTIFICATION OF AGE DISCRIMINATION IN HEALTH CARE

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Abstract

Evidence shows that age discrimination in health care is still widespread. At the same time, there has been suggestion, both in the theoretical literature and in the jurisprudence, that age is 'different' to other protected characteristics such as sex and race and thus that age discrimination may sometimes be permissible in circumstances in which discrimination on other grounds, such as sex or race, may not. This is chiefly because, it is argued, if a 'complete life view' of equality is taken, age discrimination may not produce the same distributive inequalities as does discrimination on other grounds.

This thesis responds to these arguments by asking what other – dignity-related - harms, age based distinctions in health care may cause. Dignity is widely agreed to be an important normative foundation for anti-discrimination law and features prominently in judicial and ethical debate on a range of issues in medical law. It is not an easy concept to define, however. There is no legal or theoretical consensus as to its meaning and legal uses of dignity involve appeal to a range of different and sometimes conflicting concepts. Rather than advocating one particular conception of dignity, the thesis identifies the variety of meanings of dignity evident in two contexts of close relevance to the problem at hand - equality law and medical law – and considers the answers to which these different meanings may give rise.

The purpose of the discussion is to contribute to a debate as to the approach that courts should take in assessing whether particular instances of age discrimination in health care can be justified. It concludes that, on several conceptions of dignity, age-based distinctions may give rise to dignity harms which cannot be ignored or discounted by taking a complete life view of equality. As a result, courts should tread carefully before adopting a starting point which assumes age to be different and should develop their approach to justification accordingly.

CONTENTS

CHAPTER ONE: INTRODUCTION

'I do think that the human rights values of dignity, respect for individuals, privacy and non-discrimination have so much to offer in the care of older people. They should, as the Human Rights Committee recommended, inform everything that policy-makers, regulators, providers and carers try to do, difficult though it often is. That would make it a world in which we might not mind so much about growing old.'[1]

Introduction and research question

This thesis explores whether the use of age to determine access to publicly funded health care is compatible with human dignity. Its purpose in doing so is to contribute to an assessment of the approach courts should take in deciding whether such treatment can be legally justified under the Equality Act 2010. While the Act prohibits discrimination on grounds of age in the provision of public services, including health care, both direct and indirect age discrimination may be (legally) justified where the otherwise discriminatory treatment is 'a proportionate means of achieving a legitimate aim.'[2]

Concern about age discrimination in health and social care remains widespread. Much of this arises in consequence of widely publicised accounts of mistreatment and neglect of older patients in hospital and in care homes. Nobody argues that such treatment is acceptable or justifiable, although of course it is linked, among other things, to a lack of resources.[3] Alongside these wholly unacceptable examples of age discrimination, however, there is evidence of uses of age to determine access to treatment which are not as obviously objectionable. This evidence, discussed in detail in *chapter two*, suggests that chronological age is commonly used as a proxy for, for example, the risk that a particular condition will occur or the capacity of a patient to benefit from a particular treatment or intervention and that treatment is offered or denied as a result. Many, but by no means all, of these instances of age-based rationing concern older patients.[4] It is discrimination of this type with which this thesis is primarily concerned, for it is in relation to these (arguably) less pernicious uses

[1] Baroness Hale, writing extra judicially, (2009) 'Dignity' *Journal of Social Welfare and Family Law* 31(2) 101-108 at p. 108.
[2] Section 13.
[3] The Mid-Staffordshire NHS Foundation Trust Enquiry (2013) *Report of the Mid-Staffordshire NHS Foundation Trust Enquiry: Executive Summary* (The Stationery Office, London).
[4] While this thesis considers age discrimination against the old and the young, it does not consider the question of whether and when children should be treated differently from adults in this context. Children fall outside the scope of the age provisions of the Equality Act in respect of goods and services (S28(1)(a)) and while there are clearly important areas of overlap, questions regarding distinctions between children and adults in healthcare raise some separate and significant issues which are beyond the scope of this work.

of age that the question of legal justification is likely to arise. As will be seen, a case is made for maintaining some instances of age-based rationing both by some of those engaged in the provision of health care and in the theoretical literature.

The questions of whether and when age discrimination may be justified are complicated by arguments that age is 'different' from other characteristics protected by the Equality Act such as sex and race. The ability to legally justify direct age discrimination challenges the view that direct discrimination (outside the bounds of some very tightly defined exceptions) is simply wrong and that wider justification of direct discrimination should not be permitted.[5] It forces us to consider afresh what it is that is wrong with discrimination. For if we are to accept that age discrimination is justifiable in a wider set of circumstances than is permitted for discrimination on other grounds, we must also accept at least one of two possibilities. The first is that there are circumstances in which direct sex and race discrimination (and discrimination on other grounds) *ought* also to be justifiable, beyond those currently allowed by the legislation. The second is that age is different from other characteristics in ways that mean at least *some* uses of age to determine access to benefits are permissible in circumstances in which, and for reasons that, the use of other characteristics such as sex and race would not be. As will be seen in *chapter three,* in order to explain why (and thus when) discrimination on grounds of age is sometimes justified, courts – when they have addressed this problem directly - have tended to adopt the second approach. 'The answer' suggested Lady Hale in *Seldon,* 'must be that age is different.'[6]

Two arguments as to why age is different are of particular interest here. First is the argument that a 'complete life view' of equality means that age discrimination does not give rise to the same distributive inequalities as discrimination on other grounds because inequality at any particular moment in time does not result in inequality across a lifetime. If it is the lifetime assessment of equality that matters, then, unlike sex or race, the use of age to ration benefits, so the argument goes, is not likely to result in any distributive inequality. Second is the argument, sometimes called the 'fair innings' argument, that age discrimination is not only justified but is required in order to secure equality between generations. In a health care context this argument draws on the fact that older patients all have an advantage over

[5] For an interesting debate on this point see Bowers, J. and Moran, E. (2002) 'Justification in direct sex discrimination law: breaking the taboo' *Industrial Law Journal* 31(4) 307-320 and Gill, T. and Monaghan, K. (2003) 'Justification in direct sex discrimination law: taboo upheld' *Industrial Law Journal* 32(2) 115-122.
[6] *Seldon* v *Clarkson, Wright and Jakes (a Partnership)* [2012] UKSC 16 at 4.

younger patients because they have lived for more years. These arguments are explored in more depth in *chapter four*.

While some criticisms of the complete life view and fair innings arguments are raised, however, the purpose of this thesis is not to contend that the use of age to ration benefits will always give rise to the same distributive inequalities as would the use of other characteristics. Rather, the purpose is to focus attention on the *other*, dignity related, harms to which using age in this way may give rise. It draws a number of conclusions. The first is that, on most accounts of what dignity means, the use of age to ration access to medical intervention risks harming the dignity interests of the individual patient. These 'dignity' harms cannot easily be discounted by taking a complete life view of equality. The second is that – if dignity is an important aim of anti-discrimination legislation - due attention should be paid to these dignity harms by the courts in an assessment of proportionality. This is not to suggest that dignity harms can never be outweighed by other important interests, or indeed by the dignity interests of others. But because age is no different from other characteristics in respect of these dignity harms then, where they are present, courts should be wary of adopting an 'age is different' approach as the starting point for their analysis.

The argument brings together a wide range of literature: legal, theoretical, medical and economic on both age discrimination and dignity. Its contribution is in identifying and applying the issues of particular relevance to the problem of justifying age discrimination in health care. It is worth stressing at this stage that three years since the coming into force of the relevant provisions of the Equality Act, there are no reported cases in which courts have had to adjudicate claims of age discrimination in the provision of health care.[7] Largely for this reason, one imagines, while there is a significant and growing body of legal literature considering age discrimination in the workplace,[8] including dignity-based assessments,[9] there

[7] Although reportedly claims were initiated in respect of both upper and lower age limits for IVF, see chapter two, fn.33. There are reported cases involving indirect discrimination on grounds of race and of disability (*Eisai Limited v The National Institute for Health and Clinical Excellence* [2007] EWHC 1941 (Admin)) and breach of the Public Sector Equality Duty in relation to gender reassignment (*R (on the application of AC) v Berkshire West Primary Care Trust (Equality and Human Rights Commission Intervening)* [2011] EWCA Civ 247).
[8] See, for example Sargeant, M. (2015) 'Working in the UK without a default retirement age: health, safety and the oldest workers.' *Industrial Law Journal* 44(1) 75-100; (2013) 'Distinguishing between justifiable treatment and prohibited discrimination in respect of age' *Journal of Business Law* 4, 398-416; (2010) 'The default retirement age: legitimate aims and disproportionate means' *Industrial Law Journal* 39(3), 244-263; Vickers, L. (2013) 'Pensioning off the mandatory retirement age: implications for the higher education sector' *Legal Studies* 33(2) 289-311; (2013) 'Age equality and retirement: squaring the circle' *Industrial Law Journal* 42(1), 61-74; Manfredi, S. and Vickers, L. (2009) 'Retirement and age discrimination: managing retirement in higher education' *Industrial Law Journal* 38(4) 343-364.

remains a lack of academic legal commentary on age discrimination in healthcare. Of course it is still early days. However, there is also some research to suggest that legal advisors, when faced with instances of discrimination in health care (on any ground), are more likely to recommend pursuing a claim in medical negligence than one founded on anti-discrimination rights.[10] Various reasons for this are given including difficulties in proving discrimination (discussed further in *chapter two*) as well as the perception that judicial deference, evident in public law challenges to measures which implicate resource allocation, will mean that defendants will find it easy to justify discrimination by invoking resource constraints.[11] The issue of judicial deference is discussed further below.

Dignity is chosen as a principle against which to assess these examples of age discrimination for two main reasons. First, and as explained in *chapter seven*, dignity is often argued to be a, or even the, normative underpinning of anti-discrimination law, although there is considerable uncertainty about what dignity entails. An account of anti-discrimination law which ascribes a normative role to dignity should be able to offer an understanding of the ways in which (relevant conceptions of) dignity may be harmed (if at all) by age-based distinctions. Second, because it is perhaps in the area of bioethics and medical law that the concept of dignity is at its most developed in relation to a range of legal and moral problems (such as, for example, issues of consent or assisted dying). Further, denial of dignity is popularly identified as the 'wrong' of age discrimination in a health care context, certainly in relation to those forms of age-based ill treatment (such as neglect) which few would wish to justify. There is therefore scope to explore how far dignity, as understood in these contexts, can further our understanding of which age-based practices should be prohibited and which (if any) accepted.

The difficulty faced by any attempt to assess age discrimination against the demands of dignity is that, as the discussion of the theoretical, legal and empirical literature on dignity in *chapters five, six and seven* will make clear, there is much dispute about what dignity means, whether it means anything at all and, if it does mean something, how it relates to other rights,

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[9] Alon-Shenker, P. (2012) 'The Unequal Right to Age Equality: Towards a Dignified Lives Approach to Age Discrimination' 25:2 *Can JL & Jur* 243; (2013) ''Age is different': Revisiting the Contemporary Understanding of Age Discrimination in the Employment Setting' 17:1 *Canadian Labour & Employment Law Journal* 31.
[10] European Union Agency for Fundamental Rights (2013) *Inequalities and multiple discrimination in access to and quality of healthcare* (Publications Office of the European Union, Luxembourg).
[11] ibid. Other reasons given included low non-pecuniary damages in discrimination law, especially when compared to awards for medical negligence, and difficulties presented by the 'comparator requirement' in EU anti-discrimination law.

interests and values. The thesis does not engage in a theoretical defence of dignity, or of any particular conception of it. Rather the aim of the analysis is to understand the implications of different accounts of dignity for the justification of age discrimination. It will be seen that some accounts of dignity are compatible with each other whereas others conflict. What is needed, of course, if dignity is to be a useful legal concept, is clarity as to its meaning in the particular context in which it is used. Where meanings conflict, courts will need to make a choice between them.

There is also an issue as to whether theoretical and/or empirical accounts of dignity are capable of translation into a justiciable concept. Thus, for example, the Law Commission concluded that dignity was too imprecise a concept to serve as a foundational statutory principle for adult social care legislation: '[w]hile a legal structure can be constructed in a way that is conducive to dignity – or even in a way which undermines it – it is difficult to build a legal structure on the imprecise notion of dignity.'[12] By contrast, Waldron suggests that dignity is particularly 'at home' in law. Rather than attempt to construct a legal meaning of dignity from a theoretical understanding of the concept, he argues, we should take legal meanings of dignity as our starting point.[13] In any event, and as will be evident from the body of this thesis, it is clear that dignity plays an – increasingly - important role both in the UK and in other jurisdictions across a range of areas of law. Moon and Allen, writing in 2006, noted an 'exponential' growth in the dignity discourse in the courts in England and Wales, particularly in relation to claims involving discrimination.[14]

This thesis considers both theoretical and empirical accounts of dignity but its focus is predominantly on its legal meanings. If dignity is to do useful legal work in interpreting the Equality Act, it seems as well to start with accounts of dignity which have already been deployed by legislatures and courts. Having introduced the broad categories of meanings of dignity in *chapter five*, therefore, *chapters six* and *seven* aim to establish the meanings of dignity in the two legal contexts of closest relevance to the problem at hand – health care law and equality law – before considering the implications of these different meanings for age-based rationing in health care.

[12] Law Commission (2011) *Adult Social Care* (LAW COM No 326) at 4.35
[13] Waldron, J. (2009) 'Dignity, Rank and Rights' *The Tanner Lectures on Human Values* delivered at University of California, Berkley, April 21-23 2009.
[14] Moon, G, and Allen, R. (2006) 'Dignity discourse in discrimination law: a better route to equality?' *European Human Rights Law Review* 6, 610-649.

The remainder of this chapter does three things. First, it provides some background context to the current law by looking briefly at the evolution of the prohibition on age discrimination in health care. Second it makes some introductory remarks on the nature of the test for justification – the proportionality test – both in order to make clear the ways in which its application may incorporate concern for dignity and in order to identify the scope for judicial deference to affect the analysis. Finally, it outlines the development of the argument in the subsequent chapters.

Background to the prohibition of age discrimination in health care in the Equality Act

The existence of age discrimination within the NHS was acknowledged by the New Labour government when it came into office in 1997. Instead of legislation to address the problem, the government's initial approach was to seek to 'root out' age discrimination through the introduction the new National Service Frameworks, which aimed to improve standards in the NHS in a number of respects. The National Service Framework for Older People was introduced in 2001 with the aim of eliminating age discrimination as its first key standard.[15] The Framework makes clear that health care is to be provided regardless of age, on the basis of clinical need alone. However, while recent reviews have concluded that there has been progress in tackling age discrimination since the introduction of the National Service Framework, there is ample evidence that discrimination remains.[16]

A change of approach to tackling age discrimination in the provision of services, including health care, was signalled by the 2007 Discrimination Law Review.[17] This consultation proposed, among many other things, to legislate to extend the prohibition on age discrimination, introduced in respect of employment in 2006,[18] to the provision of goods and services, including those by public authorities, under the auspices of harmonising and simplifying the law. The White Paper which followed, *Framework for a Fairer Future*, set out a rather more positive message about the commitment to eradicating 'unjustified' discrimination on grounds of age in the provision of goods and services.[19] However, it made clear that there were areas where differential treatment based on age was considered to be

[15] Department of Health (2001) *National Service Framework for Older People* (Department of Health, London).
[16] See chapter two.
[17] Department of Communities and Local Government (2007) *Discrimination Law Review, A Framework for Fairness: Proposals for a Single Equality Bill for Great Britain: A Consultation Paper* (DCLG, London).
[18] The Employment Equality (Age) Regulations 2006 (SI 2006/714).
[19] Government Equalities Office (2008) *Framework for a Fairer Future – The Equality Bill* (Cm 7431) (HMSO).

justified and desirable: 'We want to make sure we only outlaw unjustified discrimination without unintentionally stopping things that are beneficial to particular age groups.'[20]

In April 2009 The Department of Health commissioned a report on age discrimination in health and social care with a remit to produce recommendations on how the ban on age discrimination in health and social care proposed in the Equality Bill should be implemented.[21] It was asked specifically to look at the issue of what kind of exceptions, if any, should be introduced. The report recommended that no area of health or social care be removed altogether from the scope of the ban. In respect of specific, less draconian, exceptions, however, the report was equivocal. It concluded that there was nothing wrong in principle with the introduction of exceptions but neither was there a compelling need for any, given the ability of service providers to justify policies which would otherwise be discriminatory under the general justification provisions. On the one hand, it was argued, national policies which differentiate on grounds of age - such as targeted flu vaccinations or cancer screening - appeared likely to satisfy the test for justification, thus rendering specific exceptions unnecessary. On the other hand it was acknowledged that there is a risk that the courts would not agree with this assessment of the policies - and that in this context, exceptions may serve a useful purpose so as to provide greater legal certainty. In any event, further work would be needed in order to decide which exceptions may be appropriate.

Eventually the government decided that there should be no specific exceptions to the ban on age discrimination in health and social care. This decision was explained as stemming from a concern that the creation of exceptions might result in the continuance of illegitimate forms of differentiation. This was despite the fact that the 'exceptions' approach has been taken in respect of other protected characteristics such as sex.[22] Instead, it was argued, in the absence of specific exceptions, age will be able to be taken into account in decision making only when is can shown to be a proportionate means of achieving a legitimate aim. It is therefore a matter entirely for the courts to determine which age-based practices - or practices with a disparate impact on different age groups - satisfy the test for justification.

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[20] ibid, p.17.

[21] Carruthers, I. and Ormondroyd, J. (2009) *Achieving age equality in health and social care: a report to the Secretary of State for Health* (Department of Health, London)

[22] Thus, for example, single sex services, including in the provision of health care, are permitted under Schedule 3, Part 7, Section 26 of the Equality Act where it can be shown that a joint service would be less effective and the limited provision amounts to a proportionate means of achieving a legitimate aim. This includes circumstances in which the extent to which the service would be required by one sex makes it not reasonably practicable to provide joint services.

The Proportionality Test: Harm and Deference

In order to legally justify age discrimination in health care, defendants will be required to demonstrate that their actions or policies are 'a proportionate means of achieving a legitimate aim.'[23] There are two aspects to the proportionality analysis which are of particular interest for the purposes of this thesis and will therefore be introduced below. First is the scope of proportionality analysis to incorporate consideration of the harms created by prima facie discrimination. Second is the scope for judicial deference to manifest itself in the analysis.

Weighing Harms

The proportionality test provides a legal mechanism for incorporating consideration of the full range of harms and wrongs to which discrimination may give rise into an analysis of when age (and other) discrimination may be justified. However, as Baker argues, both the UK courts and the Court of Justice of the European Union ('CJEU') have failed to pay sufficient attention to the core feature of proportionality which should be part of any version of the test - the need to consider properly the impacts of the discrimination on the claimant, and on the wider community, and to weigh these impacts in order to decide whether the harm caused by the discrimination is disproportionate to the aims pursued.

In areas governed by EU Law, which includes the majority of existing jurisprudence under the Equality Act and its predecessors, the proportionality test is to be interpreted in line with the relevant Equality Directives. These require that the contested measure be shown to be both 'appropriate' and 'necessary' for achieving the legitimate aim.[24] Thus, action may not be proportionate where it goes further than necessary in order to achieve the aim (and therefore results, perhaps, in harms which could have been avoided without compromising the achievement of the aim). Although both the CJEU and UK courts sometimes engage in the weighing of the impacts or harms caused by the prima facie discrimination, this is not consistently the case.[25] Nor is it something which appears to be required by this version of the test. For once satisfied that the aim is legitimate and the measure is necessary to achieve it, there is no reason for the court to consider the harm caused by the measure to the claimant

[23] Equality Act 2010 Sections 13(2), 19(2)(d), 158, 159 and Schedule 9

[24] See Article 2 of Council Directive 2000/78 establishing a general framework for equal treatment in employment and occupation; Article 2 of Council Directive 2000/43 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin; and Article 2 of Council Directive 2006/54 on the implementation of the principle of equal opportunities and equal treatment of men and women etc (recast).

[25] Baker, A. (2008) 'Proportionality and Employment Discrimination in the UK' Industrial Law Journal 37(4), 305-328.

and others.[26] Baker has argued that, at least in an employment context, the UK Courts sometimes engage in a balancing exercise which ignores necessity, and sometimes do the opposite: 'While UK judges embrace balancing in order to avoid being required to apply a necessity test, when the facts appear to indicate that the means were necessary, balancing goes out the window. It is difficult to avoid the conclusion that the domestic judiciary's discomfort with second-guessing lawmakers and decision makers leads it to shut its eyes to impacts.'[27] Outside EU Law, as is currently the case for health care, including in cases falling under Article 14 of the European Convention on Human Rights (ECHR) where a proportionality test is used to determine whether discrimination is justified, a range of approaches to proportionality analysis are evident. These include both a 'balancing' version of the test and a very weak version which simply requires an assessment of whether the measure is 'appropriate' to the aim in question.[28]

The strongest version of the proportionality test requires courts not only to consider whether a measure is appropriate and necessary to achieve a legitimate aim, but also to engage in weighing of harms against aims in order to determine whether the harm caused by the measure outweighs any benefits the achievement of the legitimate aim may create. This form of proportionality is sometimes called strict proportionality or proportionality *stricto sensu*.[29] Incorporating this form of balancing into the analysis of whether discrimination is justified may result in a finding that even treatment necessary to achieving a legitimate aim may be held not to be justified where the harmful impacts of the treatment are given sufficient weight. Baker argues that courts should be strongly encouraged to perform this essential part of the proportionality analysis by the production of evidence of the range of harmful impacts – psychological, economic and sociological – that discrimination may cause.[30]

It is within an analysis of proportionality *stricto sensu* that there is scope for the full range of potential harms which may result from age discrimination to be considered, including harm to

[26] For discussion of this point see Connolly, M. (2001) 'Discrimination Law: Justification, Alternative Measures and Defences Based on Sex' 30(3) Industrial Law Journal 311-318 although compare Baker who argues that 'the ECJ approach to proportionality, at least with regard to the justification of indirect discrimination, guarantees proportionality stricto sensu by requiring a level of scrutiny that goes beyond striking an ad hoc balance, in effect giving discriminatory impact a presumptively high weight by approving as justified only means necessary to meet a real need of the business.' ibid. at p. 308.
[27] Baker, ibid, at p. 311.
[28] See Lord Hoffmann, writing extra judicially, (1999) 'The influence of the European Principle of Proportionality upon UK Law' in Ellis, E. (ed.) *The Principle of Proportionality in the Laws of Europe* (Hart, Oxford)
[29] See Craig, P. (2008) *Administrative Law* (6th edition) (Sweet & Maxwell, London), especially chapter 19.
[30] Baker, note 25, above. Baker here is writing about justifying indirect discrimination but the same considerations apply equally to direct discrimination

dignity interests. Indeed in some of its case law on age discrimination there is evidence that the CJEU has weighed harmful impacts as part of its proportionality analysis although neither consistently nor explicitly. Thus in *Palacios* the fact that adequate financial provision had been made for those who were to be subject to mandatory retirement was relevant to a finding that the measure under consideration was proportionate;[31] and in *Kukudeveci* the fact that the disputed measure would have different impact on different individuals was relevant to a finding that it was not proportionate.[32] The conclusions of this thesis assume that there is, and certainly that there should be, scope for this form of analysis in the determination of whether age discrimination in health care is justified.

Judicial Deference and Intensity of Review

In reviewing the acts of the executive, the judiciary have long recognised an important concern as to the proper scope of their intervention. Traditionally, this has manifested itself in a culture of 'deference' and a reluctance to scrutinise the decision making of public authorities beyond an assessment of rationality, legality or procedural impropriety.[33] In particular, there has been a strong reluctance to substitute the views of the court for those of the public authority, provided that the latter comply with these basic minimum standards. The notion of deference has been the subject of a wealth of judicial and academic comment both as to the appropriate level of deference in particular contexts and as to whether deference can properly be seen as a legal doctrine in its own right.[34] Broadly speaking, two main reasons are normally given as to why (some form of) deference is appropriate and necessary in the context of public law.

The first of these relates to the separation of powers and to democratic accountability. The concern is that in exercising too intense a scrutiny of matters of public policy, the judiciary may be overstepping their constitutional function and usurping the role of democratically elected decision makers (or those to whom authority to decide has been devolved by elected bodies). This concern often manifests itself where highly sensitive or 'political' issues such as national security or resource allocation are at stake. The view that resource related decisions should be made by those who are democratically answerable to the electorate was articulated forcefully by Lord Bingham in *R v Cambridge Health Authority, ex parte B,* a case which

[31] *Palacios de la Villa v Cortefiel Servicios SA* [2008] 1 C.M.L.R. 16.
[32] *Kucukdeveci v Swedex GmbH & Co KG* [2010] 2 C.M.L.R. 33.
[33] *Council of Civil Service Unions v Minister for the Civil Service* [1985] A.C. 374.
[34] For a useful account of the debate on both of these issues see Allan, T.R.S. (2011) 'Judicial deference and judicial review: legal doctrine and legal theory' 127 *Law Quarterly Review* 96-117.

involved consideration of the refusal of the Health Authority to fund lifesaving medical treatment for cancer for a nine year old patient. In refusing to quash the decision of the Authority he held 'Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which a court can make.'[35] Fredman, among others, however, has argued that, in the context of developing jurisprudence under the Human Rights Act, the judiciary have recently begun to shift their approach to deference in recognition that protection of individual human rights is an essential part of democracy rather than something necessarily ranged against it.[36] Indeed King argues that in consequence of the Human Rights Act, issues of resource allocation have ceased to be 'non-justiciable'. Instead, where Human Rights are involved, the relevant debate has now shifted to the question of what intensity of review is appropriate.[37]

The second, though related, concern of the judiciary in scrutinising decisions of public authorities relates to what is often termed 'institutional competence.' Judges often feel ill equipped to adjudicate on questions of resource allocation. Significantly, the judiciary will express concern that they lack the perspective necessary to understand the full implications of resource allocation decisions which represent a balance struck between a very wide range of interests. As Fredman puts it: 'The bipolar, reactive, dispute-based nature of judicial processes means that judges cannot achieve the wide lens necessary to make polycentric decisions.'[38]

Of course not all of these concerns will necessarily arise in the same way in respect of adjudication of claims under the Equality Act, as they do in public law contexts, even where it is the decisions of public bodies which are challenged. In the Equality Act, Parliament has expressly delegated to the judiciary the role of determining the situations in which discrimination may be justified (or indeed whether it has occurred at all). Nonetheless, the question of whether discrimination by a public authority is justified may need to be resolved by reference to essentially 'political' criteria. For example, in the context of allocation of scare resources there is room for significant disagreement as to how the needs of various

[35] [1995] 2 All ER 129 (CA) at para. 137.
[36] Fredman, S. (2006) 'From deference to democracy: the role of equality under the Human Rights Act 1998' 122 *Law Quarterly Review* 53-81.
[37] King, J. (2007) 'The Justiciability of Resource Allocation' 70(2) *Modern Law Review* 197-224.
[38] Fredman, note 36, above.

groups - protected and not protected by the Equality Act - should be weighed against each other and this may well be something that the judiciary will feel reluctant to engage in.

Deference may potentially manifest itself in the application of the proportionality test in at least two ways: first in the choice of proportionality test to be applied, from among those identified above; and second in the approach the judiciary take to the question of establishing proportionality in terms of the rigour with which the claims of the state (or claimant) are examined and the weight given by the judiciary to the views of the primary decision maker.

There is not sufficient case law on discrimination by public authorities to discern any clear patterns of judicial deference in relation to justification under the Equality Act or Equality Directives. On the one hand, a rigorous approach to the analysis is evident in a number of cases, including *Elias* where Mummery LJ explicitly rejected the argument that the concepts of margin or appreciation and discretionary judgment which had evolved in Article 14 jurisprudence should also apply to the proportionality analysis under the (then) Race Relations Act 1976.[39] On the other hand, Ellis notes, for example, that the CJEU has abandoned its 'intense' application of the proportionality test in relation to social security matters where, instead, it has allowed member states to show only that 'it reasonably believes the measure to be necessary to achieve a social policy aim, not that it actually and demonstrably is necessary in order to achieve that aim.'[40]

In any event it seems that there is certainly potential for concerns about deference to arise in relation to claims of discrimination in the allocation of health care resources. As was noted above, this already appears to be a concern for legal advisors when considering which remedy to pursue for clients alleging discrimination (on any ground) in health care. This scope for deference matters for the purposes of this thesis because, as will be seen in *chapter three*, one of the issues courts have considered important in determining the degree of scrutiny appropriate in relation to claims under Article 14 has been the nature of the characteristic on which the discrimination is based; arguments that 'age is different' have sometimes been deployed to justify a lighter touch review. The argument that will be made here is that, where the treatment under question involves harms – specifically dignity harms -

[39] *Secretary of Defence v Elias* [2006] EWCA Civ 1293; see also Sargeant, M. (2010), note 8, above, who notes that while affording a wide margin of appreciation in relation to the legitimacy of the the aims advanced by the government, in *R (on the application of Age UK) v Secretary of State for Business Innovation and Skills* [2009] EWHC 2336 (Admin), the High Court was willing to take a rather more rigorous approach to the question of proportionality, considering the available evidence as to the impacts of forced retirement at a range of ages.
[40] Ellis, E.(1999) 'The Concept of Proportionality in European Community Sex Discrimination Law' in Ellis, E. (ed.) *The Principle of Proportionality in the Laws of Europe* (Hart, Oxford) at p.179.

which cannot be discounted by taking a complete life view of equality, there seems to be no reason why the intensity of review undertaken by the courts should be different from that for other characteristics.

Chapter outline

Chapter two reviews the evidence for age discrimination in health care and the reasons (as far as we can know them) why the continued use of age to make certain treatment decisions is supported by some of those involved. It concludes that, among other things, age is used widely as a proxy for capacity to benefit from a particular medical intervention for reasons of cost effectiveness and because it is sometimes judged to be in the best interests of the patient. Chapter three then sets out the legal framework, and the approach of courts, to the use of characteristics such as age as proxies in order to determine access to benefits. It identifies the considerations courts commonly take into account when deciding whether the use of certain characteristics as proxies is permissible. It will be seen that age is treated differently in this respect not only by the legislation (in permitting direct age discrimination to be justified) but also in the approach of the courts. Versions of the complete life view and fair innings arguments are evident in the judicial reasoning. Chapter four assesses the theoretical debate on the complete life view and the fair innings arguments. In addition to some empirical concerns about the fairness of any distribution according to age, objections to these arguments have stressed the importance of interests which are or may be harmed as a result of age discrimination and which cannot be easily discounted by taking a complete life view. It will be suggested that dignity is a candidate for one of these interests.

Chapters five, six and seven then explore the meanings of dignity. Chapter five introduces the concept and identifies some broad distinctions in the uses of and meanings of dignity, both in the theoretical literature and by the courts. Chapters six and seven then examine in more detail the ways in which dignity is used in healthcare law and then equality law. A range of different meanings is apparent, not all of them consistent with one another. Finally chapter eight considers what dignity-related harms – on these various accounts of dignity – may arise in consequence of using age to deny access to healthcare. It concludes that the use of age in this way involves harm to a range of the dignity interests identified in the preceding chapters and considers the implications of this for the legal justification of age discrimination in healthcare.

CHAPTER TWO: THE EVIDENCE OF AGE DISCRIMINATION IN HEALTH CARE

Introduction

This chapter reviews the evidence of age discrimination in the provision of health care by the National Health Service. The aims in doing so are twofold: to identify the nature and extent of the use of age in determining access to health care; and - where it is possible to do so - to identify the types of reasons given by clinicians, commissioners and policy makers for their continued use of age-based practices.

The review is not intended to be comprehensive. It is limited in two main respects. First, for reasons explained in chapter one, the focus will be on those aspects of age-based provision where issues of justification are likely to arise. The review will therefore be of evidence of practices which may amount to direct or indirect discrimination, should they not be justifiable. While mistreatment which amounts to harassment remains a serious issue of age discrimination in health and social care provision - as demonstrated by a wealth of recent media interest in this issue – these instances of discrimination are not the focus of this thesis as they raise no issue of legal justification. More specifically, the review will concentrate on practices that clinicians and policy makers may plausibly wish to defend – where the literature suggests that the use of particular age-based practices are in fact defended by those employing them, or where there is continued debate and discussion as to whether they are defensible. Thus some of the worst examples of age discrimination – the serious neglect of older patients on hospital wards for example – are not considered here, as it is highly unlikely that any provider would attempt to publically defend them.

Second, the focus will be on evidence of age discrimination in the allocation of resources – whether this is at the level of policy or local commissioning or the result of individual clinical judgment. Thus, while there is ample evidence of age discrimination in the delivery of services also – ranging from a lack of appropriate facilities in hospital wards to barriers in accessing available services such as physical access and transport services – these will not be considered here.

Identifying age discrimination

Before considering the evidence for the existence of age-based practices in the provision of healthcare, it is important to note, briefly, some of the difficulties in establishing the role played by age in the provision of health care.

Lack of Research

Literature reviews of age discrimination in primary and secondary care and mental health services, commissioned by the UK Government in 2009 in anticipation of the introduction on the ban on age discrimination, noted that there was a paucity of systematic research on the issue.[1] Most of the relevant literature focuses on treatments for individual conditions, services and practices but that there is very little research that has attempted to take an institution wide view. In part this is due to the inability of many organisations within the NHS to provide accurate data on their service users, creating difficulty in assessing whether services are provided fairly as between different age groups.[2]

Covert Discrimination

As with discrimination on other grounds and in other contexts, much age discrimination in health care provision is covert. Research suggests that since the 2001 National Service Framework for Older People which provided that 'NHS services will be provided, regardless of age, on the basis of clinical need alone'[3] there has been a significant reduction in the *explicit* use of age as a criterion for access to services.[4] Instances of overt age-based practices do continue to exist – and these are discussed in detail below. However, much of the 'evidence' of potential age discrimination rests on patterns of treatment which suggest a relationship between age and access to treatment or services and establishing the reasons such patterns exist has proved difficult.

[1] Centre for Policy on Ageing (2009) *Ageism and age discrimination in primary health care in the United Kingdom* (Centre for Policy on Ageing, London)*;* (2009) *Ageism and age discrimination in secondary health care in the United Kingdom* (Centre for Policy on Ageing, London)*;* (2009) *Ageism and age discrimination in mental health care in the United Kingdom* (Centre for Policy on Ageing, London).
[2] Healthcare Commission, Audit Commission and Commission for Social Care Inspection (2006) *Living Well in Later Life: a review of progress against the National Service Framework for Older People* (Healthcare Commission, London)
[3] Department of Health (2001) *National Service Framework for Older People* (Department of Health, London)
[4] above, n, 2

Of course, difficulty in establishing discrimination is nothing new. The difficulties claimants face in proving discrimination in all walks of life have been acknowledged by the courts[5] and have resulted in changes to the law to shift the burden of proof to the defendant once a case of prima facie discrimination is made out.[6] However, to compound the usual difficulties in proving discrimination it is suggested that there are a number of particular difficulties which arise in the health care context. First, the nature of medical expertise means that patients and carers may not be well placed to access or assess the clinical evidence themselves in order to determine whether a decision to refuse treatment (or to treat) is supported by the evidence, or whether and what additional considerations are involved.[7] Identifying the possibility that age may have played a part in clinical decision making may thus be even more of challenge than it is in other contexts.

Second, the correlation between advancing chronological age and the increased likelihood of ill health or frailty is common knowledge. The older the patient, the more likely they are to have more than one condition (co-morbidity) and to be in receipt of more than one type of medicine (polypharmacy); and the presence of co-morbidities and/or polypharmacy will often inform a decision about whether and how to treat an individual patient for a particular condition. Thus, patterns of treatment which appear to correlate with chronological age may instead reflect a correlation with the increased presence of comorbidity which in turn affects the risks and benefits of a particular course of treatment. As Dey and Fraser have pointed out 'precisely because clinical judgment is meant to involve holistic assessment of individual needs, it is no easy matter to assess the way age is used at the clinical level.'[8]

Exclusion from Clinical Trials

It is common for older people to be excluded from clinical trials. As a result, there is a lack of evidence of the effect of many drugs (or treatments) on the older population, resulting in understandable reluctance on the part of clinicians to prescribe those drugs or refer those treatments for this age group.[9] A decision to refuse a particular treatment to a patient because

[5] See, e.g., Neill, LJ in *King* v *The Great Britain-China Centre* [1991] EWCA Civ 16 at para. 36: 'It is important to bear in mind that it is unusual to find direct evidence of racial discrimination. Few employers will be prepared to admit such discrimination even to themselves.'
[6] Equality Act 2010 s136
[7] See Levenson, R. (2003) 'Institutional Ageism' *Community Care* (August)
[8] Dey, I. and Fraser, N. (2000) 'Age-based rationing in the allocation of health care' *Journal of Ageing and Health* 12(4) 511-537
[9] Centre for Policy on Ageing (2009) *Ageism and age discrimination in secondary health care in the United Kingdom*, above n, 1, section 8;

of their age may therefore simply reflect a lack of evidence of the risks and benefits of that treatment for an individual of a particular age, rather than any assumptions made by the individual clinician about the relationship between patient age and the appropriate course of treatment. The reasons given for the exclusion of older people from trials include the increased likelihood of the presence of comorbidity/polypharmacy which may complicate (and increase the cost of) a successful trial; and concerns about the ethics of involving 'vulnerable' patients in research.[10] The discriminatory impact of excluding older people from clinical trials was recognised by the government during their consultation on the extension of the prohibition of age discrimination to the NHS and they stated their intention to work with organisations responsible for the design of clinical trials to improve the rate of inclusion of older people.[11]

Multiple Discrimination

Another difficulty in establishing the role of patient age in decisions about whether or how to treat is that of multiple discrimination, which occurs where individuals receive less favourable or inappropriate treatment as a result of a combination of aspects of their identity. Research conducted in five EU member states, including the UK, suggests that discrimination in access to and quality of healthcare exists because of combinations of characteristics such as age and nationality or age and disability. Thus, for example, older migrant patients are reported to have experienced stereotyping and prejudice in accessing appropriate treatment because of perceptions that the combination of their age and nationality meant they may be feigning illness in order to claim particular benefits.[12]

With these caveats in mind, the following sections outline the evidence of age-based practices in determining which treatments or interventions should be available on the NHS. The first section summarises the evidence of overt use of age in decision making; the second section explores the evidence for the use of age in determining access to treatment by individual clinicians or providers, where this is not explicitly mandated or recommended by policy.

[10] ibid.
[11] Government Equalities Office (2012) *Equality Act 2010: Banning age discrimination in services, public functions and associations: Government response to the consultation on exceptions* (Government Equalities Office, London) section 3.5
[12] European Agency for Fundamental Rights (2013) *Inequalities and multiple discrimination in access to and quality of healthcare* (EU Publications Office, Luxembourg)

Evidence of explicit discrimination

The National Service Framework for Older People, introduced in 2001, included 'rooting out age discrimination' as the first of its eight standards.[13] A series of audits carried out to assess the scope of existing age discrimination in anticipation of and following the introduction of the framework, concluded that while age discrimination remains, progress has been made in eradicating discriminatory practices. In particular, there has been a significant reduction in the use of age limits as explicit barriers for access to treatment, medication or services. Thus, for example, while a 1991 study found 19% of the coronary care units surveyed used explicit age-related admissions criteria, by 2001 this was less than 1%.[14] An audit by the Department of Health in 2002 found very few remaining policies which explicitly determined access on the basis of age this was confirmed in a review commissioned by the Department of Health in anticipation of the provisions of the Equality Act 2010.[15] Four examples of these are looked at in detail below, in order to explore the types of reasons given for the use of age in each case. These are the use of 'quality adjusted life years' in determining cost effectiveness of treatment (with in vitro fertilisation discussed as an specific example); national screening programmes; kidney allocation policy; and mental health services.

Quality Adjusted Life Years (QALYs)

QALYs are a measure used to calculate the cost effectiveness of a particular treatment or medical intervention. They combine the (health related) quality of life a patient may expect to have post intervention with their remaining life expectancy. The number of QALYs generated by an intervention can then be combined with the cost of that intervention to create a cost-effectiveness ratio – the cost per QALY. In this way QALYs provide a 'common currency' to allow those with responsibility for resource allocation to compare the costs and benefits of a range of interventions and to set priorities accordingly. QALYs are used to inform decisions about resource allocation by the National Institute for Health and Care Excellence (NICE), particularly in their evaluation of new and existing health technologies,

[13] Note 3, above.
[14] Centre for Policy on Ageing (2009) *Ageism and age discrimination in secondary health care in the United Kingdom* above, n 1, at p.45.
[15] Carruthers, I. and Ormondroyd, J. (2009) *Achieving age equality in health and social care: a report to the Secretary of State for health* (Department of Health, London).

and are used more widely in research which informs commissioning decisions nationally (see discussion of screening programmes below) and locally.[16]

There are several ways in which the use of QALYs in allocating resources may amount to prima facie age discrimination. First, and much discussed in the academic literature, is the fact that given the use of remaining life expectancy in the calculation of the number of QALYs and intervention produces, the method is potentially indirectly discriminatory. Other things being equal, a fifty year old will normally produce less QALYs than a thirty year old and more than a seventy year old. It is important to note that a younger patient will not *always* generate more QALYs than an older patient. A particular younger patient may have lower life expectancy than a particular older patient; or the quality of life of a particular younger patient (or younger patients in general) may be less improved by an intervention than that of a particular older patient (or older patients in general) to such an extent that the younger patient/s produce less QALYs overall. But where two patients both have normal life expectancy, and a given intervention is likely to produce the same health related quality of life improvement in each, the intervention will produce more QALYs in the younger patient. Further, given the increased likelihood of comorbidity in the older patient, the lower their health related quality of is likely to be pre – and post – intervention. This, also, will serve to reduce the number of QALYs an intervention is capable of producing.[17] For both of these reasons, the cost-per-QALYs of an intervention for an older patient will often be higher than the cost-per QALY of the same intervention for a younger patient. When QALYs are used to inform decisions about which interventions should be funded, and what the access criteria for interventions should be, then the methodology has the potential to disadvantage older patients.

Second, is the concern that the method used to calculate health related quality of life may itself be indirectly discriminatory by failing to take into account the experiences and priorities of older patients. It is argued that the currently used measure of health related quality of life – the EQ-5D – may overstate the importance of physical functioning and understate the importance of other indicators; in addition there is evidence that the measure is not

[16] www.nice.org.uk. Until 1 April 2013 NICE was known as the National Institute for Health and Clinical Excellence.

[17] The same difficulty is also faced by those with pre-existing disabilities whose quality of life score may be lower, post intervention, notwithstanding the success of the intervention itself. See discussion in Newdick, C. (2005) *Who Should We Treat? Rights, Rationing and Resources in the NHS* (Oxford, OUP) *;* Singer, P. et al (1995) 'Double jeopardy and the use of QALYs in Health Care Allocation' *Journal of Medical Ethics* 12: 144-151.

sufficiently sensitive to factors such as changes in expectations and perceptions of health with age.[18] This may lead to an underestimation of health related qualify of life in older people which, in turn, will impact on the number of QALYs an intervention is capable of generating in an older patient.

Finally, it is argued, in giving equal value to all remaining years of life in the calculation of the number of QALYs produced by an intervention, this methodology fails to recognise the added value we may attach to the final years – or months, weeks or days – of life. Thus an intervention which is able to prolong life for a relatively short period may be found to generate a very high cost per QALY and therefore be ineligible for funding. Given that most people die in older age, this feature of the use of QALYs is again charged with age discrimination.[19]

For these reasons, then, the use of QALYs in calculations of cost effectiveness, where cost effectiveness then informs resource allocation, certainly has the *potential* to give rise to indirect discrimination on grounds of age. It is argued, however, that while this theoretical potential exists, the context in which QALYs are used in practice - and in particular their use in health technology appraisals by NICE - means that the methodology does not in fact disadvantage older people. [20] One reason for this is that NICE generally operates at a 'macro' level – determining which from a range of possible treatments or interventions are most cost effective for society a whole, rather than at an individual level – determining which members of society should be eligible for a particular treatment. Because of this, it is claimed, it is NICE's normal practice, when evaluating an intervention, to 'assume that what applies to one age group within a particular appraisal will apply inter alia to others'[21] and to aggregate the QALYs an intervention produces across a range of ages. Thus most of NICE's recommendations do not restrict access by age – treatments are generally recommended for all ages or for none – and much of the theoretical potential for QALYs to generate discriminatory results is thereby avoided.

[18] Hickey, A. et al (2005) 'Measuring Health Related Quality of Life in Older Patient Populations: A Review of Current Approaches' *Pharmacoeconomics* 23(10) 791-3; See also Edlin, R. et al (2008) *Cost Effectiveness analysis and ageism: a review of the theoretical literature* (Leeds Institute of Health Sciences, Leeds).
[19] See e.g. Harris, J (1985) *The Value of Life* (Routledge: London); (2005) 'It's not NICE to discriminate' *Journal of Medical Ethics* 31: 373-375
[20] Stevens, A et al (2012) 'National Institute for Health and Clinical Excellence Appraisal and Ageism' *Journal of Medical Ethics* 38: 258-262
[21] ibid.

This does not eliminate the potential for discrimination altogether however. While there are very few age stratified results among NICE's recommendations (where access to a particular intervention is recommended only for a particular age group) some do exist;[22] and it remains the case that interventions which would primarily benefit the older population (rather than society as a whole) or interventions which produce only a short extension to life in anyone, are able to produce fewer QALYs (although there are not – yet – examples among NICE's decisions of treatments not being recommended for this reason).[23]

It is argued, on behalf of NICE, that procedures are in place to mitigate against the possibility that their appraisals will give rise to unfair age discrimination in these situations.[24] These include, in particular, the use of NICE's Social Value Principles and End of Life rules in its decision making. The End of Life rules provide that additional value, not adequately captured by QALYs, be given to the last few months of life in some situations where intervention may extend the life of those with short life expectancy;[25] the circumstances in which these rules should apply is the subject of further research.[26] The Social Value Principles are intended to inform all the decisions made by NICE in relation to health technologies and include

Principle 3: Decisions about whether to recommend interventions should not be based on evidence of their relative costs and benefits alone. NICE must consider other factors when developing its guidance, including the need to distribute health resources in the fairest way within in society as a whole.

and

Principle 7: NICE can recommend that the use of an intervention is restricted to a particular group within the population (e.g. people under or over a certain age, or for women only), but only in certain circumstances. There must be clear evidence about the increased effectiveness

[22] ibid. One example of an age stratified result – access to IVF - is discussed in more detail below.
[23] Edlin, note 18, above, p.72.
[24] Stevens et al, note 20, above.
[25] National Institute for Health and Clinical Excellence (2009) *Appraising life-extending end of life treatments* (NICE, London). Note that one of the criteria is that the treatment in question is indicated for 'small patient populations' (at 2.1.3, small undefined) which will inevitably limit the circumstances in which these rules can mitigate the potentially age discriminatory effect described above.
[26] Stevens et al, note 20, above.

of the intervention in this subgroup, or other reasons relating to fairness for society as a whole, or a legal requirement to act in this way.[27]

Thus decision makers are called to be alert to the potentially age discriminatory impact of pure QALY based cost effectiveness analysis, and to consider the broader issues, set out in the principles. Where cost effectiveness analysis dictates that treatment should only be recommended for particular age groups, the permissible reasons for implementing age limits for access are made clear in the Social Value Judgments: age should only be used as an access criteria for treatment or intervention where: there is evidence that age is a good indicator for some aspect of patients' health status and/or the likelihood of adverse effects of the treatment; or there is no practical way of identifying patients other than by their age (for example, there is no test available to measure their state of health in another way); or there is good evidence, or good grounds for believing, that because of their age patients will respond differently to the treatment in question.[28] It is less clear what criteria must be satisfied to recommend a treatment not be offered where that treatment would benefit – only or mainly – a particular age group, and a QALY analysis suggests it is not cost effective. While regard for 'fairness' is stressed in the principles above, there is no detail on what fairness involves here. It is, however, at least clear what fairness is not. The Social Value Principles also stress that health should not be more highly valued in some age groups than in other, and that different social roles at different ages should not be taken into account in making decisions on cost effectiveness.[29]

Thus there is considerable debate as to whether the use of QALYs in the methodology of NICE (and other commissioners) amounts to prima facie indirect age discrimination; and whether – where it does so – it is justifiable. These issues are raised again in Chapter 4. Certainly the government's view, set out during the consultation process on the implementation of the age discrimination provisions, is that fundamental changes in NICE's methodologies are unlikely to be necessary in order to comply with the legislation.[30]

In Vitro Fertilisation (IVF)

[27] National Institute for Health and Clinical Excellence (2008) *Social Value Judgments: Principles for the development of NICE Guidance* (2nd edition) (NICE, London). This Guidance predates the Equality Act 2010 and is stated to be subject to the requirements of the Act.
[28] Ibid. at 6.3.
[29] Ibid.
[30] note 11, above.

An example of NICE guidance where recommended access to treatment is determined by age is IVF. Public funding for IVF - at any age - is controversial and raises interesting issues about the boundaries of 'health' and the circumstances in which public funding should be provided to assist couples to conceive.[31] In February 2013 NICE published revised guidance on access to IVF and other fertility treatment.[32] Among other recommendations, the revised guidance suggests that where other clinical criteria are met, women between the ages of 40 and 42 should be eligible for one free cycle of IVF treatment while women under 40 should be offered up to three cycles. Women aged 43 and over are not eligible for treatment. There is no lower age limit. The previous recommended lower and upper age limits for access to treatment had been 23 and 39.

Local commissioners are not obliged to follow this guidance[33] and many currently do not. Some Clinical Commissioning Groups (CCGs) offer no funded IVF treatment at all; others use different age limits. The decisions of (the then) Berkshire East Primary Care Trust to retain 35 as the upper age limit and of (the then) Portsmouth City Primary Care Trust to make 30 the lower age limit for access to IVF treatment were both reported to be subject to possibly the first legal challenges under the age discrimination provisions under the Equality Act 2010.[34] Since then Portsmouth CCG has removed the lower age limit from its Assisted Conception Policy, but both Portsmouth and East Berkshire CCGs have retained 35 as the upper age limit for referral for treatment, notwithstanding the NICE recommendations.[35] The

[31] See, e.g. McTernan, E. (2015) 'Should Fertility Treatment be State Funded?' *Journal of Applied Philosophy* 32(3) 227 – 240.

[32] National Institute for Health and Clinical Excellence *Fertility: assessment and treatment for people with fertility problems* (February 2013, Clinical Guideline 156). Available at https://www.nice.org.uk/guidance/cg156 (last accessed October 2015).

[33] NICE technology appraisals are binding on local Clinical Commissioning Groups ('CCGs'- and formerly on Primary Care Trusts) under The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, Regulation 34. However CCGs may depart from other forms of NICE Guidance where they have good reason to do so (see *R v North Derbyshire Health Authority ex parte Fisher* [1997] 8 Med. L R 327). Following *R (on the application of Rose) v Thanet Clinical Commissioning Group* [2014] EWHC 1182 (Admin) CCGs will need to demonstrate a clear clinical case for departure from NICE guidance.

[34] Laura Donnelly, 'Couple sue for IVF in landmark 'age discrimination' case' *The Telegraph* (London, 1 December 2012) available at http://www.telegraph.co.uk/news/health/news/9716432/Couple-sue-for-IVF-in-landmark-age-discrimination-case.html (accessed October 2015); Jonathan Brown, Jeremy Lawrence, 'Too young to have IVF; 24 year old Andrea Heywood fights for her right to fertility treatment' *The Independent* (London, 4 June 2012) available at http://www.independent.co.uk/life-style/health-and-families/health-news/too-young-to-have-ivf-24-year-old-andrea-heywood-fights-for-her-right-to-fertility-treatment-7814790.html (accessed October 2015).

[35] SHIP 8 Clinical Commissioning Groups' Priorities Committee (Southampton, Hampshire, Isle of Wight and Portsmouth CCGs) *Policy Recommendation 002: Assisted Conception Services* (September 2014) available at

minutes of the Board meeting at which Portsmouth CCG confirmed the upper age limit (among other eligibility criteria) note that the decision was taken as a result of the clinical evidence that the effectiveness of IVF declines after the age of 35 and not because of cost.[36] Interestingly, a public consultation carried out before the decision was taken suggests that the majority (86%) of the public locally supported either use of the NICE age limits or a raising of the upper boundary to 38.[37]

In revising its guidance, NICE used a new economic model specially developed for determining access criteria. This model compared cost effectiveness of 1, 2 or 3 cycles of IVF with 'expectant management' (waiting to see whether conception occurs naturally). Treatment effectiveness was measured in QALYs and cost effectiveness was measured for each of these four treatment options, for 198 clinical scenarios across the age range 20 (chosen as representing two years infertility from the age of 18) to 45 (chosen as a good estimate of end of natural reproductive ability). QALY gains related to improvements in health states for couples hoping to conceive and did not take into account new lives created as a result of treatment (although this was acknowledged to be a difficult task owing partly to a lack of research on changes in heath states produced by infertility/its reversal.) This meant that, for the first time, the remaining life expectancy of the woman undergoing the treatment was a factor in determining the cost effectiveness of providing IVF at a given age. Age (along with a range of other factors including cause of infertility, reproductive history) was also used to predict the likelihood of success of the treatment. In other words age was used to calculate cost effectiveness by using it as a proxy *both* for the likelihood of success *and*, if successful, for the duration of any health benefit thereby produced.

Screening

Several of the few remaining examples of explicit rationing by age within the NHS relate to national screening programmes. Existing national screening programmes for adults screen for breast, bowel and cervical cancer and for vascular disease. All include both upper and age

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www.portsmouthccg.nhs.uk (accessed October 2015); NHS South, Central and West Commissioning Support Unit, Berkshire East *Policy Statement 11g: Assisted Reproduction Services for Infertile Couples* (November 2013) available at http://www.fundingrequests.cscsu.nhs.uk/berkshire-east/cosmetic-and-other-surgeries-berkshire-east/ (accessed October 2015).

[36] Portsmouth CCG, AI 03 Minutes of Governing Board Meeting of 21 January 2015, 210115, GB180315, item 13, available at http://www.portsmouthccg.nhs.uk/About-Us/march-2015_2.htm (accessed September 2015).

[37] Portsmouth CCG, AI 13 Assisted Conception Appendix 4, Papers for Governing Board Meeting 21 January 2015, GB210115, available at http://www.portsmouthccg.nhs.uk/About-Us/january-2015_2.htm (accessed September 2015).

limits for access although in some cases those outside the age band are able to request screening tests despite being excluded from routine screening invitations.[38] Even where screening is available on request, there is evidence that take up is much lower.

Women (but not men) between the ages of 50 and 70 are invited for breast cancer screening every three years. Women over the age of 70 do not receive an invitation for screening but are able to request a mammogram every three years while those below the age of 50 are able to access screening only after referral by their GP for specialist intervention, where, for example, family history or other clinical factors suggest this would be beneficial. An extension of this age range to 47 – 73 is currently being phased in nationwide with the aim of completing the extension of routine invitation for screening for this age group by 2016.[39] In 2013 the All Party Parliamentary Group on Breast Cancer recommended that the trial be extended to those aged 74-76 and, should take up in this age group be sufficient, to those age 77-79 in a second phase.[40] However, earlier this year, a follow up report expressed disappointment that these recommendations had not been implemented and that while Public Health England remained supportive in principle, as did healthcare professionals involved in the age extension trial, funding remained an issue. Interestingly, they noted that 'at present two thirds of the funding is being spent on women at the younger end of the age extension trial (47-49) as there are more younger women. This means that there is limited funding available for the age extension into the older group and there appears to be little possibility of securing additional funding.'[41]

Bowel Cancer Screening is currently offered every two years to those between the ages of 60 and 69 while those over 69 who wish to be screened can request this. A programme to extend the screening service to everyone aged between 70 and 74 years is currently being rolled out across the country but is not yet complete.[42] Screening before the age of 60 by request is

[38] There is some minor variation in the upper and lower age limits in England, Scotland, Wales and Northern Ireland – the age limits given below are those which apply in England. See www.cancerscreening.nhs.uk.
[39] www.cancerscreening.nhs.uk; Department of Health (2011) *Improving Outcomes: A Strategy for Cancer* (Department of Health, London).
[40] All Party Parliamentary Group on Breast Cancer (2013) *Age is just a number: The report of the parliamentary inquiry into older age and breast cancer* (Breakthrough Breast Cancer, London).
[41] All Party Parliamentary Group on Breast Cancer (2015) 'Two years on: age is just still a number: Progress report on the All Party Parliamentary Group on Breast Cancer's enquiry into older age and breast cancer' (Breakthrough Breast Cancer, London).
[42] http://www.cancerscreening.nhs.uk/bowel/age-extension-bowel-cancer-screening.html (accessed October 2015).

currently unavailable but a new test (flexible sigmoidoscopy) is currently being piloted in addition for men and women between 55 and 60. Cervical cancer screening is currently offered to women between the ages of 25 and 65, or beyond for those who have a history of abnormality or who have never been screened.[43] The vascular screening programme is now available to those between 40 and 74.[44] In addition to these uses of age limits for access to screening, it is also worth noting that the UK National Screening Committee does not currently recommend prostate cancer screening.[45] While clearly this applies to all age groups, and thus does not involve any direct discrimination, prostate cancer is a disease which is particularly prevalent in older men and thus the decision not to provide a national screening programme for this particular cancer is an example of potential indirect discrimination. It is not easy to find clear explanations for the use of age limits in each case – or of the particular age limits used - in the available public policy materials. However, what follows attempts to summarise the reasons that are provided.

First, the upper and lower age limits chosen may reflect the evidence on the incidence of the relevant disease in particular age groups. Chronological age is used as a proxy for the likelihood of an individual developing the condition the screening programme is intended to detect. The national cancer screening website suggests that the incidence of the disease is the reason for the upper age limit for cervical cancer screening –'Generally speaking, the natural history and progression of cervical cancer means it is highly unlikely that women of 65 and over will go on to develop the disease.'[46] Similarly, the Department of Health explains that 'eight out of ten people who get bowel cancer are over the age of sixty.'[47]

Second, even where evidence suggests that those in a particular age group may be at risk of developing the condition, screening tests may be unavailable because of evidence that the screening test itself is likely to be ineffective in that age group due to the changes in the body associated with changes in age. This appears relevant particularly in the case of cervical and breast cancer where the lower age limits are both justified by reference to the inability of existing screening tests to generate reliable results in particular age groups. In relation to breast cancer, there is evidence that the current screening test (conventional mammography) is less effective in pre-menopausal breast tissue; the lower age limit is therefore used as a

[43] http://www.cancerscreening.nhs.uk/cervical/about-cervical-screening.html (accessed October 2015).
[44] http://www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx (accessed October 2015).
[45] http://www.cancerscreening.nhs.uk/prostate/ (accessed October 2015).
[46] http://www.cancerscreening.nhs.uk/cervical/faqs.html (accessed August 2015)
[47] Department of Health, (2011) *Bowel Cancer Screening:The Facts* (Department of Health, London).

proxy for the end of menopause.[48] In relation to cervical screening, the lower age limit reflects concern that normal changes in the younger cervix may result in a high rate of 'false positives' should routine screening be extended to younger women.[49]

Third, and related, there is concern that, in certain age groups, the risks and disadvantages of the screening tests may outweigh the benefits. There is a concern both that 'false positives' (generated by screening in age groups where the screening test is less reliable) may increase anxiety and lead to unnecessary and potentially harmful treatment; and that 'true positives' may likewise result in avoidable anxiety and intervention where the age of the patient and the normal progression of the disease mean that the disease would be unlikely to manifest itself naturally during the lifetime of the patient. Thus, a recent review of the lower age limit for cervical cancer concluded that extending testing to women below the age of 25 could lead to adverse psychological impacts and to an increase in unnecessary treatment which in turn could have harmful side effects in relation to future childbearing.[50] Similarly, for both bowel[51] and prostate[52] cancer screening it has been argued that, given that most older patients in whom screening would detect cancer are likely to die of something else before the cancer reaches its advanced stages, the negative impacts of screening in older age outweigh the benefits.

Fourthly, it has been argued, at least in relation to cervical cancer screening, that using age as the entry point into the screening programme, rather than determining when screening is appropriate for an individual patient based on other factors, ensures that the system is fair, consistent and workable. There was a real danger of stigmatising women if the first screen was to be based on sexual activity or smoking - lifestyle based risk factors which would in fact be the best indicator for when the first cervical screen would be beneficial.[53]

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[48] http://www.cancerscreening.nhs.uk/breastscreen/faqs.html (accessed October 2015). Digital mammography is, according to the same source, more effective in younger women.

[49] Minutes of the Advisory Committee on Cervical Screening, 19 May 2009 available at http://www.cancerscreening.nhs.uk/cervical/cervical-review-minutes-20090519.pdf (accessed October 2015); for similar concerns about the risk and impact of false positives in breast cancer screening in younger women see Rawdin, A. and Madan, J. (2008) 'An initial assessment of the merits of extending breast cancer screening aged 47-49 years to assist the appraisal of options for extending the NHSBSP with appendix considering women aged 71-73' (School of Health and Related Research ('ScHARR'), Sheffield).

[50] ibid.

[51] Quarini, C. and Gosney, M. (2009) 'Review of evidence for a colorectal cancer screening programme in elderly people' *Age and Ageing* 38(5) 503-508.

[52] Burford, D. et al (2010) *Prostate Cancer Risk Management Programme; information for primary care: PSA testing in asymptomatic men: Evidence Document (2nd ed)* available at http://www.cancerscreening.nhs.uk/prostate/pcrmp02.pdf (accessed October 2015).

[53] Minutes of the Advisory Committee on Cervical Screening, 19 May 2009, note 49 above, at 7.2.

Fifth, there is lack of evidence as to the impact of screening on particular age groups in some cases. This is certainly true in relation to breast cancer where trials are currently underway to test the costs and benefits of extending the screening programme so that individuals are invited for two extra screens during their lifetime, one before and one after the current lower and upper age limits of 50 and 70, thus extending eligibility for the screening programme to those between the ages of 47 and 73. This policy change is part of a broader programme to improve UK statistics on cancer mortality and does not appear motivated by any particular concerns about the use of age limits for access. However, reduction in cancer mortality in the population is unlikely to be achievable without an improvement in mortality in the older population, where the highest incidence of almost every form of cancer is found.[54]

Finally, there is cost effectiveness. The national screening programmes do not come under the auspices of NICE guidance and there is no clear explanation of how cost effectiveness is determined in relation to the various screening programmes, nor how information on cost effectiveness is then used in decision making in relation to age limits. Clearly many of the other reasons discussed above are relevant to cost effectiveness. Research on cost effectiveness is certainly evident in research which informs the decisions about the ages at which the various screening programmes should be offered. Thus in relation to the lower age limits for both vascular and bowel cancer screening, and upper and lower age limits for breast cancer screening, QALYs were used to model the cost effectiveness of a range of lower age limits.[55] Interestingly, in relation to breast cancer screening, a QALY based assessment suggested that the extension to the upper age limit was likely to be more cost effective than the extension to the lower age limit, even though the potential QALY gain in preventing mortality from breast cancer is much larger for younger women. The reasons for this were that screening was found to generate more 'true positives' and fewer 'false positives' in older women.[56]

Some literature challenges the evidence on which some of the current screening age limits are based. Indeed a review of the literature on the use of age in access to screening programmes concluded that 'while some (screening programmes) have a sound evidence base and for others there is no available evidence, some are clearly discriminatory and are not justifiable

[54] Department of Health (2011), note 39, above.
[55] Department of Health (2008) *Putting prevention first – vascular checks: risk assessment and management* (Department of Health, London); Whyte, S. et al (2011) *Reappraisal of the options for colorectal cancer screening: Report for the NHS Bowel Cancer Screening Programme* (ScHARR, Sheffield); Rawdin, and Madan, note 49, above.
[56] Rawdin and Madan, ibid.

by disease prevalence or any other clinical indicator.'[57] Thus, for example, while the upper age limit for vascular screening is currently 74, most strokes occur in those aged 75 or over and therefore it is important to monitor hypertension in this age group too; [58] the upper age limit for cervical cancer screening is explained – as noted above – as reflecting the fact that those over 65 are 'highly unlikely to go on to develop the disease' whereas research suggests that more women in their 70's die from cervical cancer than women under 30 and that there is a second 'peak' in the incidence of cervical cancer in those over the age of 85;[59] and it has been argued in relation to bowel cancer that there is a lack of any evidence base for the use of the upper age limit, or indeed for the effect of screening in the older population at all. [60]

Kidney Allocation

Another explicit use of age in determining access is in the allocation of kidneys for transplant from deceased donors. Age appears to be no bar to receiving a transplant *per se* - the current guidelines published by the UK Renal Association recommend that 'age is not a contra-indication to transplantation although age related comorbidity is an important limiting factor.'[61] However, the current Deceased Donor Kidney Allocation Scheme appears to use age as an explicit criterion (among others) in identifying who among those on the waiting list should be eligible to receive a donated organ. The allocation process works on a points scheme with points awarded for various characteristics. While the closeness of tissue match is always the dominant criteria for allocation, among recipients for whom the kidney would be well matched, and other things being equal, more points are awarded to younger patients.[62]

Mental Health Services

Age discrimination in mental health services has been the subject of recent research and political focus. Weaknesses in mental health provision are particularly likely to affect the

[57] Centre for Policy on Ageing (2009) *Ageism and age discrimination in secondary health care in the United Kingdom: a review from the literature* (Centre for Policy on Ageing, London) at p.22.
[58] Xavier, G. (2009) 'The new health checks must not be allowed to increase inequalities' *Nursing Times* 105(14): 9.
[59] White, C. (1999) 'Upper age limit should be raised for cancer screening' *British Medical Journal* 318: 831; www.cancerresearchuk.org
[60] Quarini and Gosney, note 51, above.
[61] Dudley, C. and Harding, P. (2011) *Clinical Practice Guidelines: assessment of the potential kidney donor recipient* (5th Edition) Final version 12 January 2011 (UK Renal Association) available at www.renal.org/guidelines (accessed October 2015).
[62] NHSBT *Kidney Transplantation: Deceased Donor Organ Allocation* Policy Pol 186/4 November 2014 available at http://www.odt.nhs.uk/information-for-patients/kidney/ accessed August 2015.

older population: thirty per cent of mental health inpatients are aged over 65.[63] While it is clear that some of the failures in provision of mental health services in the elderly population are the result of ageist stereotypes or misconceptions about mental health in the elderly – a view of mental health problems such as depression or dementia as a 'normal' part of ageing for example[64] – the key cause is normally identified as stemming from the segregation of mental health service provision for working age and older adults; in many (though not all) localities, mental health services are divided into 'adult mental health' for adults up until the age of (usually) 65 and 'older people's mental health' for those over 65.[65]

This division in service provision came about as a result of the National Service Framework for Mental Health, introduced in 1999, which redesigned mental health services for working age adults and was accompanied by significant funding to build and improve on service provision.[66] At the time, the intention was that mental health services for older people would be best dealt with under the auspices of the National Services Framework for Older People, which was to be published two years later. However, when this came, it fell short in two respects. First, it covered only dementia and depression rather than the full range of mental health problems encountered by older adults; second, by the time it was implemented structural changes in service provision meant that it was not matched by targeted funding in the same way as 'adult mental health' had been.[67] It is generally agreed that the consequence was a poorer service for older adults than for working age adults; in 2009, a consultation by the Government Equalities Office found that in some trusts older people were unable to access services that were available to younger adults.[68] Thus, while working age adults in some areas are able to access services such as crisis care, out of hours and occupational health, older adults are not.[69] For some patients this means that once they reach 65 they are transferred from the care of adult mental health to older people's mental health services and thereby excluded from services from which they had previously benefited. These – among other – features of the difference in service provision have led some commentators to

[63] Healthcare Commission (2008) *Count me in 2008: results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales* (Healthcare Commission, London).
[64] Centre for Policy on Ageing (2009) *Ageism and age discrimination in mental health care in the United Kingdom: a review from the literature* (Centre for Policy on Ageing, London).
[65] Ibid.
[66] Department of Health (1999) *National Service Framework for Mental Health* (Department of Health, London).
[67] Anderson D (2011) 'Age discrimination in mental health services needs to be understood' *The Psychiatrist* 35(1) 1-4.
[68] Government Equalities Office (2009) *Equality Bill: Making it work. Ending age discrimination in services and public functions – a consultation* (Government Equalities Office, London).
[69] Centre for Policy on Ageing, note 64, above.

conclude that 'mental health services in the NHS provide one of the few remaining examples, in many localities, of overt, institutional direct age discrimination.'[70]

However, while most agree that current divergence in the quality and quantity of service provision is unacceptable, there is debate over whether the solution lies in integrated or segregated-but-better services. One reason for the initial segregation of services was that the profile of mental health problems in the working age and the older populations is significantly different. In particular, as adults reach later life there is a decline in the prevalence of psychoses and a rise in dementia, with dementia accounting for over one third of hospital mental health patients aged 65 and over, and over half of those aged 75 and over.[71] Further, according to the Royal College of Psychiatrists, older people may develop mental health problems related to social and lifestyle changes brought about by ageing which require a specialised response.[72] Age is therefore agreed to be a good proxy for mental health needs.

The different mental health needs which may arise in the older population have led to calls to retain – but improve – separate service provision for older people. Indeed there is a concern that failure to do so could itself amount to (indirect) age discrimination by failing to recognise and respond appropriately to the needs of the older population. Thus the Department of Health, following a consultation on this issue, concluded that specialist older peoples mental health services should continue because the ageing population has particular needs; many adult mental health services are designed to meet the needs of working age adults with severe mental health problems and would fail to meet the needs of older adults with different conditions. The conclusion was that what was needed was specialist services of equivalent quality.[73] Similarly the Royal College of Psychiatrists, while arguing that an arbitrary age limit should not be used to determine the services a person is entitled to receive, were clear that age appropriate mental age services should be retained: 'it is unacceptable to offer a single, age inclusive mental health service that is not designed to meet the need of older people and to do so would be discrimination.'[74] Solutions have been suggested and, in some places, implemented which attempt to retain age appropriate services without using

[70] ibid
[71] ibid
[72] Royal College of Psychiatrists (2009) *Age discrimination in mental health services: making equality a reality (position statement PS2/2009)* (RCPsych, London).
[73] Department of Health (2009) *New Horizons: towards a shared vision for mental health – a consultation* (Department of Health, London).
[74] Royal College of Psychiatrists, note 72, above.

chronological age as the (only) criterion for determining access. These include formal agreements between working age and older adult mental health services which provide - for example - for reassessment of mental health needs at 65, rather than automatic transfer.[75] However, it appears that there is no consensus on whether older people's mental health services should be organised as a separate service.[76]

Non-overt discrimination

The previous sections have assessed some of the few remaining examples of explicit age differentiation in access to services. In addition to these examples of explicit of use as age as a criterion for access to services, there is evidence that age serves as a factor in determining whether and which services to offer in a wide range of situations involving individual clinical judgment. Age appears to affect preventative care, the likelihood of investigation and referral and the type of care and treatment (if any) subsequently available, across a range of specialities. Thus a recent report by the Royal College of Surgeons ('RCS') found that, as patient age increases, the likelihood of developing certain conditions increases but the likelihood of surgical intervention for those conditions declines.[77]

A clear example is in the case of cancer services. Most cancers are more prevalent in later life. Over half of all cancers diagnosed are in people aged 65 or over; a third of all cancers diagnosed are in those aged 75 or over.[78] Despite this age profile, however, a 2012 study by the Department of Health concluded that there is a marked decline in referral for more 'intensive' treatment – including surgical intervention – as patient age increases. Thus, for example, the incidence of breast cancer peaks in the 85+ age group but surgical intervention for breast cancer declines sharply after the age of 70.[79] This is despite the relevant NICE guideline which is explicit that surgical intervention should be offered regardless of chronological age.[80] The low rate of surgical intervention is thought to be one of the reasons cancer outcomes in those over the age of 75 may be poorer in the UK than in other comparable countries. A recent follow up study by the RCS found that this disparity was

[75] Centre for Policy on Ageing, note 64, above.
[76] ibid.
[77] Royal College of Surgeons (2013) *Access all ages: assessing the impact of age on access to surgical treatments* (Royal College of Surgeons, London).
[78] Department of Health (2012) *The impact of patient age on clinical decision making in oncology* (Department of Health, London).
[79] ibid.
[80] National Institute for Health and Clinical Excellence (2009) *Clinical Guidance for early and locally advanced breast cancer (CG80)* (NICE, London).

particularly marked in some areas, with widespread variation in the rates of surgery, and in particular breast cancer surgery, for the over 65's and over 75's depending on the geographical commissioning area: 'A number of CCGs have very few people in the over-75 age bracket who have received surgery for the procedures we analysed. For breast excision, cholecystectomy, inguinal hernia repair and knee replacement, a number of CCGs had a rate of 0 per 10,000 for the over-75s. This is despite the incidence rate for conditions that can be treated through these procedures peaking at around the age of 80.'[81]

The increasing likelihood of the presence of comorbidity and complex health and physiological changes in the older patient may be one explanation for the lower rate of surgical and (other more intensive) interventions for the treatment of cancer in the older age group. The more invasive the treatment, the greater the risks may be for those with more complex health states – and this may in turn affect both the willingness of the clinician to refer a patient for particular treatment and/or the wiliness of the patient to undergo the treatment. However, a number of studies which have attempted to control for the presence of comorbidity and other factors in their assessment of the role of chronological age in access to oncology services have found that the patterns of treatment could not be wholly accounted for in this way. The Department of Health study, for example, concluded that, in making decisions about access to oncology services, and in particular in determining the level of intensity of the treatment which should be provided 'clinicians may over rely on chronological age as a proxy for other factors which are often but not necessarily associated with age, such as comorbidities or frailty.'[82]

Similar patterns emerge in respect of other services including cardiology and stroke. While explicit age limits for access to coronary care have now disappeared, evidence suggests that older people with heart disease are less likely to receive the same level of investigation and treatment as younger patients. Likewise, elderly stroke patients are less likely to be treated in a specialist stroke unit, are less likely to receive appropriate investigation and treatment , and are less likely to be offered preventive care . These issues in secondary care are compounded

[81] Royal College of Surgeons and Age UK (2015) *Access All Ages 2: exploring variations in access to surgery among older people* (RCS, London).
[82] Department of Health (2012) note 78, above.

by evidence of low referral rates for older people by GPs for cholesterol testing and angiography and revascularisation.[83]

As with cancer care, the increased likelihood of complex health needs in the older patient, and the impact of this on the risks and benefits of certain treatments, is likely to be a relevant explanatory factor here. There is a strong correlation, for example, between increased patient age and the risk of mortality or other complications in coronary artery bypass graft surgery, which many in turn influence not only a clinician's decision to treat but also a patient's decision to consent.[84]

Nonetheless the authors of the literature review commissioned by the Department of Health to assess the evidence for age discrimination in secondary care concluded that in respect of cancer, stroke and coronary care 'evidence of the under-investigation and under-treatment of older people in cancer care, cardiology and stroke is so widespread and strong that, even taking into account confounding factors such as frailty, co-morbidity and polypharmacy we must conclude that ageist attitudes are having an effect on overall investigation and treatment levels.'[85]

Clinical assessment of a patient on the basis of chronological age – rather than on the basis of actual frailty, co-morbidity and polypharmacy - may of course involve unwarranted 'ageist' assumptions such as, for example, mistaken assumptions about the preferences or lifestyle needs of an individual patient. It may also involve the use of chronological age as a proxy for the risks and harms a course of treatment may produce in an individual patient where, for example, there is a strong statistical correlation between age and risk and no reliable test for assessing biological age.[86] There is relatively little research on the ways in which age is used by individual clinicians but that which there is suggests that chronological age may be used as a proxy for a number of indicators including risk or capacity to benefit. Thus, for example, some clinicians participating in a study of the influence of patient age on decision making on coronary care, noted that a patient's chronological age may influence their views on whether to refer them for surgery as it served as a proxy for the risk of mortality or the development of complications. Some clinicians in the same study also used patient age as a marker for

[83] Centre for Policy on Ageing (2009) *Ageism and age discrimination in secondary health care in the United Kingdom* (Centre for Policy of Ageing, London).
[84] Royal College of Surgeons (2013) note 77, above.
[85] Note 83, above at 11.2.
[86] See e.g. Department of Health (2012) note 78, above, which suggests that the lack of an objective way of assessing biological age in some contexts may lead to clinicians using chronological age as a proxy.

wider concerns about what may be in the patient's best interests. One, for example, noted that 'they wouldn't want an angiogram if they were over 70', another that 'I don't think bypass surgery in an 87 year old is in their interests.'[87] This raises interesting issues as to the appropriate limits of clinician judgment in determining what is in the best interests of the patient – and of the appropriate use of patient age in that decision making process. These issues are explored further in chapters six and eight.

Conclusions

The above review suggests that chronological age is used as a proxy for a number of different characteristics in determining access to treatment: as a proxy for the capacity of an individual to benefit from an intervention; for the type of harm which may result from an intervention; for the likelihood of such benefit or harm occurring; and, in some cases, for other indicators used to determine what may be in the patient's interest. Age is used as a proxy in this way in making decision about both individual patients and wider populations; it may be used where no better 'marker' for the relevant characteristic exists or where – for reasons including cost, practicality or fairness – age may be used in preference to other available markers. The next two chapters will consider the existing legal framework for the use of personal characteristics as proxies, and then explore the wider issues to which this gives rise in the context of theoretical debates about the appropriate use of age in resource allocation.

[87] Harries, C. et al (2007) 'Which doctors are influenced by a patient's age? A multi method study of angina treatment in general practice, cardiology and gerontology' *Qual Saf Health Care* 16 23-27.

CHAPTER THREE: STATISTICAL DISCRIMINATION AND THE LAW

Introduction

We saw in Chapter two that age can be used as a proxy in determining whether – and what kind of – health interventions may be deemed appropriate for patients. Age is used as a proxy (both for individual patients and for wider populations) for the likelihood an individual has or will go on to develop a condition, for their capacity to benefit from a particular intervention, for the risk of adverse consequences arising from an intervention, and for their health care needs. Age proxies may feature in policy guidance or recommendations and in the assessment of individual patients by their clinicians.

Prima facie, the use of age as a proxy in this way will normally amount to direct age discrimination – 'less favourable treatment because of [age]' - under the Equality Act 2010, unless it can be justified as being a 'proportionate means of achieving a legitimate aim.'[1] This is likely to be the case even where age is used as a proxy to determine which from a number of – theoretically - equally appropriate interventions or services an individual should be offered, such as the existing use of age to determine to which mental health services a patient should be referred in some localities. While segregation of services is not *automatically* 'less favourable treatment'[2] and indeed may be justifiable as a form of positive action, denial of choice has normally been held to be sufficient to satisfy the test for direct discrimination in other contexts.[3]

The previous government's view, as set out in the consultation response on exceptions to the ban on age discrimination in the provision of services, was that the use of age as a proxy may be justifiable in some contexts, but not in others. The distinctions drawn are far from clear, however: 'Whilst age should not be used as a proxy for need, some health and social services are designed and delivered to meet particular needs or conditions which are likely to be more

[1] Equality Act 2010 S13; The use of some characteristics, such as remaining life expectancy, as a proxy for capacity to benefit may amount to indirect age discrimination under S19 of the Equality Act. Where this is the case the choice of proxy may also be justified as being a proportionate means of achieving a legitimate aim, although the justification tests for direct and indirect discrimination will not necessarily be applied in the same way (see *Homer v Chief Constable of West Yorkshire Police* [2012] UKSC 15).
[2] Unless in the case of race discrimination, see S13(5) of the Equality Act 2010; and see e.g. Part 7 of Schedule 3: 'Separate services for the sexes.'
[3] See *Birmingham City Council* v *Equal Opportunities Commission* [1989] IRLR 173, HL; *Gill* v *El Vino Co Ltd* [1983] IRLR 206, CA.

prevalent in particular age groups. Commissioners and providers of health and care services should not be discouraged from taking account of age where this is justified; and providing appropriate services for individuals with similar needs which may include age-related needs. However, chronological age must not be used as a substitute for an individual assessment of a person's needs.'[4] This does not make clear whether and under what conditions commissioners can use age based restrictions on access to services (such as IVF or invitation to screening) and indeed the extent to which it is (ever) appropriate for clinicians to use chronological age as part of patient assessment. As noted in chapter one, rather than create specific exceptions permitting the use of age as a proxy in determining access to particular services (as was done in relation to financial services, for example)[5] it was decided that any use of age in determining access to health and social care should be required to satisfy the justification test. It should be a proportionate means of achieving a legitimate aim. It will thus be for the courts to decide which uses of age in decision making about access to health care are legally justified. In doing so they will need to decide what kinds of legitimate aim (if any) are capable of justifying the use of chronological age as a proxy for some other characteristic in a health care context, and what kinds of consideration will be relevant to determining whether the use of age as a proxy in achieving a particular aim are proportionate.

This chapter examines the existing legal approaches to the use of personal characteristics as proxies (sometimes called statistical discrimination) with the aim of identifying the factors which guide judicial response to their use and which therefore may be legally relevant in determining whether and when the use of age as a proxy in allocating health care may be justified. By 'proxy', here, is meant the use of one (normally easy to identify) characteristic as a substitute for another (normally harder, more expensive, or impossible to test for). Thus, for example, chronological age may be used as a proxy for fertility, for physical condition or for mental capacity. The use of proxies is closely related to the idea of stereotyping – a process defined by Lady Hale in *Roma Rights* as the assumption that an individual holds the characteristics of a group to which they belong (whether or not most members of the group do in fact have those characteristics).[6] Of course the use of a characteristic as a proxy need not involve the assumption that *all* members of a group hold that characteristic – indeed the

[4] Government Equalities Office (2012) *Equality Act 2010: Banning age discrimination in services, public functions and associations; Government response to the consultation on exceptions* (Government Equalities Office, London) at 3.7.
[5] Equality Act 2010 Schedule 3, Part 5.
[6] *R (European Roma Rights Centre and Others)* v *Immigration Officer at Prague Airport and Another* [2004] UKHL 55 at 74.

use of a proxy may be recognised as a blunt tool which is likely to result in treating some individuals as holding characteristics which they do not, but which may nonetheless be justified for one reason or another. In this way, proxies are an example of 'bright line rules' – simple tests used to determine access to benefits and entitlements which avoid the need for consideration of individual circumstances and which therefore may provide administrative workability at the expense of individual fairness.

Often (but not always) bright line rules involve the use of an easy to identify characteristic as a proxy for another which it would be much more difficult or expensive to identify. This may involve direct discrimination (where a protected characteristic is used as the proxy or bright line), indirect discrimination (where the bright line disadvantages a protected group), or neither. The use of chronological age to determine access to some benefit or other is a very good example of a bright line rule which directly discriminates. No matter how good a proxy chronological age may be for some other characteristic, it is difficult to imagine that it can ever adequately capture all and only those having that characteristic, because, as the House of Lords accepted in *Carson*, 'there could be no relevant difference between a person the day before and the day after his or her birthday.'[7]

The review of legal approaches to the use of personal characteristics as proxies will consider the discrimination law framework of the Equality Act and related EU law where direct discrimination (except on the grounds of age) is prohibited, save for tightly defined exceptions, and thus the use of protected characteristics as proxies is rarely permitted; and on the case law under Article 14 of the ECHR. Article 14 is considered both because it is here that the judiciary have most experience of considering the circumstances in which direct, as well as indirect, discrimination may be justified; and because judicial consideration of Article 14 often influences decision making under the Equality Act and its predecessors (and vice versa).[8]

The focus here will be on situations where the use of a proxy amounts to direct discrimination – that is where a protected characteristic itself is used as a proxy (such as the use of chronological age to determine access to services). Because the use of characteristics as

[7] *R (on the application of Carson) v Secretary of State for Work and Pensions and R (on the application of Reynolds) v Secretary of State for Work and Pensions* [2006] 1 AC 173.
[8] See for example R (on the application of McDonald) v Royal Borough of Kensington and Chelsea [2011] UKSC 33 but compare *Secretary of Defence v Elias* [2006] EWCA Civ 1293 where it was made clear that the test for proportionality may not be the same in relation to Article 14 claims as it was under the (then) Race Relations Act 1976.

proxies is a subset of direct discrimination, what follows will consider some wider issues relevant to justifying all forms of direct discrimination, as well as issues particular to this particular form of direct discrimination. However, given that judicial approaches to the use of bright line distinctions in general are of interest, consideration will also be given to bright lines that involve indirect discrimination - where the use of a bright line has a discriminatory impact on a particular protected group. Here, the problem with the bright line distinction is not that its use attributes group characteristics to an individual but that the impact of its use disadvantages, in particular, members of a protected group. Any claim of indirect discrimination itself, of course, relies on the claimant's ability to identify with a protected group and to show that the characteristic shared by members of that group is a reasonable proxy for some form of disadvantage. Indeed the Employment Appeal Tribunal has noted that indirect discrimination is premised on the ability to make generalised statements about groups, which amount to accurate stereotypes.[9] However, it should be remembered that the test for indirect discrimination – at least under the Equality Act – explicitly requires claimants to also show that they will be disadvantaged as individuals. Their individual circumstances are considered as well as their group membership.[10]

The legislative framework and the 'wrong' of stereotyping

In some contexts, the use of certain characteristics as proxies is simply prohibited. Under the Equality Act – and EU anti-discrimination law which it implements - most forms of direct discrimination cannot be legally justified. Thus use of sex or race as a proxy, for example, is prohibited unless covered by tightly defined exceptions including positive action, which will be considered below. This is true regardless of the aims of the use of the characteristic and regardless of whether or not the proxy stands as an accurate substitute marker for the particular skills, behaviour or needs in question. Judicial recognition of this legal fact has not always been without some misgivings. However the wording of the relevant legislation has left little room for the courts to explore whether and when the use of personal characteristics as proxies - or indeed 'stereotyping' – should be permitted.

[9] *Eweida v British Airways plc* [2009] ICR 303 at 52.
[10] Equality Act 2010 Section 19.

Two well known cases illustrate this. In *James v Eastleigh*[11] the defendant council had restricted free access to swimming to those who were of pensionable age, a policy which, because of the different state pension ages for men and women, was found to directly discriminate on ground of sex. The council argued that their purpose in providing the concession was to 'aid the needy.'[12] Pensionable age was treated as a reasonable proxy for financial means and therefore a sensible method of identifying those who would be most likely to benefit from not being required to pay. These motives were not doubted by the House of Lords but, by a majority, they held that the wording of the legislation prevented even such a well-intentioned policy. This was not without some reluctance on the part of the House, including those in the majority. Thus, Lord Goff noted that the conclusion of the court would mean that 'some people, seeking to do practical good for the best of motives, may be inhibited in the sense that they will be precluded from using gender-based criteria to achieve their purpose.'[13]

Where a provision is caught by Section 13 of the Equality Act (again, except for age) the accuracy of the proxy or stereotype is also irrelevant. The causative nature of the 'but for' test, which precludes all considerations of motive and intent, catches all uses of a personal characteristic as a proxy or stereotype irrespective of whether evidence suggests that the characteristic is a good proxy for something else. In the *Roma Rights* case[14] the House of Lords found that immigration officers at Prague airport had directly discriminated against Roma in implementing a pre-entry clearance scheme at Prague Airport. Under this scheme, leave to enter was refused to those who, in the view of the immigration officer, were intending to claim asylum in the UK. It was found that, under the scheme, Roma were four hundred times more likely to be refused entry than were other applicants. The majority in the Court of Appeal (Laws LJ dissenting) had rejected the claim of direct race discrimination on the grounds that, for reasons connected with historical and ongoing discrimination against Roma in the Czech Republic, being of Roma origin was a very good proxy for the likelihood that an individual was planning to seek asylum.[15] The House of Lords disagreed. Lady Hale, who gave the leading judgment on this issue, expressly rejected the notion that the accuracy of the proxy or stereotype in any way prevented the treatment from being discriminatory:

[11] *James* v *Eastleigh Borough Council* [1990] ICR 554.
[12] Ibid at 560.
[13] ibid at 574.
[14] note 6, above.
[15] *R (European Roma Rights Centre and Others)* v *Immigration Officer at Prague Airport and Another* [2003] EWCA Civ 666.

> 'The person may be acting on belief or assumptions about members of the sex or racial group involved which are often true and which if true would provide a good reason for the less favourable treatment in question. But 'what may be true of a group may not be true of a significant number of individuals within that group' (see Hartmann J in *Equal Opportunities Commission v Director of Education* [2001] 2 HKLRD 690, para 86, High Court of Hong Kong).The object of the legislation is to ensure that each person is treated as an individual and not assumed to be like other members of the group. As Laws LJ observed, at para 108: 'The mistake that might arise in relation to stereotyping would be a supposition that the stereotype is only vicious if it is untrue. But that cannot be right. If it were, it would imply that direct discrimination can be justified …'[16]

Two things follow from this. One is that - as a matter of law – in relation to claims of direct discrimination under the Equality Act, in respect of characteristics for which justification is not possible, the accuracy of the stereotype, just as the motive for using it, is irrelevant. The second relates to the purpose of the legislation. Lady Hale suggests that stereotyping – no matter how accurate the stereotype or how good the reason for using is – is precisely one of the things the legislation sets out to prevent; and in concurring that the use of true stereotypes may be equally 'vicious', she appears to suggest that the law forbids stereotyping because *all* stereotyping is wrong. The wrongness involves treating an individual as a member of a group rather than as an individual. Here she echoes her comments made earlier in the same year in *Ghaidan* v *Godin-Mendoza* – a challenge to sexual orientation discrimination under Article 14 – in which she had explained the wrongness of gender and racial stereotyping as follows:

> It was wrong because it depended on stereotypical assumptions about what a woman or a black person might be like, assumptions which had nothing to do with the qualities of the individual involved: even if there were any reason to believe that more women than men made bad customers this was no justification for discriminating against all women. It was wrong because it was based on an irrelevant characteristic which the woman or the black did not choose and could do nothing about.[17]

This emphasis on wrongness of stereotyping – of attributing group characteristics to an individual –was challenged by the introduction of age as a new protected characteristic under the anti-discrimination law framework in 2006.[18] Unlike all the other protected characteristics, direct age discrimination could be justified. This meant that the application of an age-based proxy was – at least potentially – justifiable, something which did not sit

[16] Note 6, above, at 82.
[17] *Ghaidan v Godin Mendoza* [2004] UKHL 30 at 130.
[18] The Employment Equality (Age) Regulations 2006 implementing the relevant provisions of Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation (the 'Framework Directive').

comfortably with these earlier judicial pronouncements as to the wrongs of stereotyping. The discomfort expressed by Lady Hale in her judgment in *Seldon*[19] indicates the difficulty here. In considering whether a mandatory retirement age could be justified, the Supreme Court were asked to consider whether avoiding harming the dignity of older workers, who would otherwise – it was argued – eventually be subject to potentially humiliating reviews of their capabilities, was a legitimate aim. This assumes that chronological age is a good proxy for declining capability. In assessing this argument, Lady Hale noted that

> 'The fact that most women are less physically strong than most men does not justify refusing a job requiring strength to a woman candidate just because she is a woman... It would be consistent with this principle to hold that the fact that most people over a certain age have slower reactions than most people under that age does not justify sacking everyone who reaches that age irrespective of whether or not they still do have the necessary speed of reaction.'[20]

However, in the face of the ECJ's acceptance of 'dignity' as a legitimate aim, she concluded that this approach to the use of age as a proxy for capability must be permissible within the EU law framework.

The rigid legal framework governing direct discrimination grounds other than age under the Equality Act, outlined above, had not previously provided the judiciary space with opportunity to consider when – if ever - the use of other characteristics as proxies could be justified and to establish principles which could have then been applied in the case of age. The wording of the prohibition on direct discrimination, together with the unavailability of legal justification, precluded it. Nor did the new legislation governing age – particularly as it had been interpreted by the Court of Justice - appear to allow the judiciary the option of concluding that, just as for other protected characteristics, all uses of age as a proxy must be wrong. The only real option available to rationalise this different legal approach to age was to conclude – as the Supreme Court did in *Seldon* – that the reason for the different approach must lie in the nature of the characteristic itself. Where this approach struggles, however, is in providing the courts with any clear guidance as to how to distinguish between the circumstances in which age stereotyping is acceptable, and those in which it is not. EU Law provides some specific guidance, in the context of workplace discrimination, as to the

[19] *Seldon* v *Clarkson, Wright and Jakes (a Partnership)* [2012] UKSC 16.
[20] ibid.at 58.

circumstances in which direct age discrimination may be permitted.[21] Beyond this, however, there is little help to be found in case law under the Equality Act and its predecessors.

Protected and suspect characteristics

While the Equality Act and its predecessors have left relatively little discretion to the courts in adjudicating claims of direct discrimination, the open textured nature of Article 14 of the ECHR – under which a wide range of characteristics have been recognised as being protected and direct as well as indirect discrimination can be justified - has generated judicial discussion as to the circumstances in which the use of proxies or bright line distinctions, which discriminate directly or indirectly on the grounds of some protected characteristic, are justifiable. In establishing their approach, the UK Courts have identified the ground of discrimination as the key (though not the only relevant) factor and have drawn an important distinction between discrimination on 'suspect' and on 'other' grounds – a distinction which is also evident (though less explicitly so) in the jurisprudence of the European Court of Human Rights ('ECtHR'). Suspect grounds are those 'which prima facie appear to offend our notion of respect due to the individual.'[22] Lord Hoffmann explained the significance of the distinction as follows:

> There are two important consequences of making this distinction. First, discrimination in the first category cannot be justified merely on utilitarian grounds, e.g. that it is rational to prefer to employ men rather than women because more women than men give up employment to look after children. That offends the notion that everyone is entitled to be treated as an individual and not a statistical unit. On the other hand, differences in treatment in the second category (e.g. on grounds of ability, education, wealth, occupation) usually depend upon considerations of the general public interest. Secondly, while the courts, as guardians of the right of the individual to equal respect, will carefully examine the reasons offered for any discrimination in the first category, decisions about the general public interest which underpin differences in treatment in the second category are very much a matter for the democratically elected branches of government.[23]

Where the grounds of discrimination are not 'suspect', the courts have had little difficulty in accepting their use as proxies, even where this causes hardship to those who fall on the wrong side of the bright line they create. Utilitarian justifications, including administrative convenience and cost saving, have been readily accepted (subject to some constraints relating

[21] Framework Directive, note 18, above, Article 6
[22] *Carson*, note 7 above, at 182
[23] ibid

to proportionality which are discussed further below). This approach, among other things, involves recognition by courts that in many cases bright line distinctions are used in the context of decisions as to the appropriate distribution of resources among different groups and competing interests – essentially political decisions. Thus in *Blecic* v *Croatia* the ECtHR indicated that, particularly where lines are drawn to balance interests of different groups in allocating resources, a wide margin of appreciation as to the location of the line would normally be appropriate. 'The court accepts that where state authorities reconcile the competing interests of different groups in society, they must inevitably draw a line marking where a particular interest prevails and another one yields, without knowing precisely its ideal location.'[24] In the national courts this approach manifests itself under the doctrine of judicial deference, outlined in chapter one, whereby less intensive review is normally given to decisions of a political nature. Where the grounds of discrimination are 'suspect', on the other hand, as Lord Hoffmann explained in *Carson*, courts will conduct a more intensive review of the reasons offered by way of justification, and will be unwilling to accept justification based simply on utilitarian considerations, notwithstanding the resource implications of the decision under review.

The ECtHR, while not articulating this distinction between suspect and other grounds in quite the same way, has nonetheless recognised that discrimination on some of the grounds of discrimination protected by Article 14 will require 'very weighty reasons' in order to be justified, whereas others will not. Grounds in this first category, so far, include sex,[25] race,[26] religion,[27] sexual orientation,[28] birth outside marriage[29] and (at least some types of) disability.[30] In *Kiss* v *Hungary*[31], for example, the Court considered a voting restriction which applied to those who had been placed under part or full guardianship by the state for reasons including mental illness. The Hungarian government had explained that the purpose of the measure was to ensure that 'only citizens capable of assessing the consequences of their decisions and making conscious and judicious decisions should participate in public affairs.'[32] While accepting that this aim was legitimate, the Court accepted the applicant's

[24] *Blecic* v *Croatia* [2005] 41 E.H.R.R. 13 at 64
[25] *Petrovic* v *Austria* [2001] 33 E.H.R.R. 14
[26] *Timishev* v *Russia* [2007] 44 E.H.R.R. 37
[27] *Vojnity* v *Hungary* [2013] (application no: 29617/07) ECtHR
[28] *EB* v *France* [2008] 47 E.H.R.R. 21
[29] *Inze* v *Austria* [1988] 10 E.H.R.R. 394
[30] *Kiss* v *Hungary* [2013] 56 E.H.R.R. 38; *Kiyutin v Russia* [2011] 53 E.H.R.R. 26
[31] ibid
[32] ibid at 25

argument that it was disproportionate to apply a blanket voting ban on all those under guardianship without an individual assessment of their capabilities. The applicant had pointed out that the characteristic of having been assessed as needing to be placed under guardianship for reason of mental disability, was in fact a poor proxy, in many cases including his own, for the ability to make voting decisions. The Court held that very weighty reasons were needed to justify distinctions made on grounds of mental or intellectual capacity, justifying its own strict scrutiny in this case by reference to social exclusion caused by historical prejudice against certain vulnerable groups. Such prejudice, it argued, 'may entail legislative stereotyping which prohibits the individualised evaluation of their capacities and needs.'[33]

In *Timishev* v *Russia*[34] the Court suggested that the use of ethnic origin as a proxy was not capable of being objectively justified at all. In this case the Russian government had issued an order that no one be permitted to cross the border into the Kabardino-Balkaria Republic (part of the Russian Federation) if they were of Chechen origin or appeared to be of Chechen origin. No justification for this policy was offered before the Grand Chamber (although the national court had considered that the aim was the prevention of terrorism and had consequently found that the order did not discriminate unlawfully) and therefore the Court did not need to consider matters relating to the legitimacy of the aim or the proportionality of the measure. They simply concluded that 'no difference in treatment which is based exclusively or to a decisive extent on a person's ethnic origin is capable of being objectively justified in a contemporary democratic society.'[35]

It is not yet clear where age sits among these distinctions. The issue has not yet been considered in Strasbourg. In the UK courts, discussion of the issue has not resulted in any great clarity. In *Carson* itself, age was identified as a 'contemporary example of a borderline case' between these two categories of 'suspect' and 'non suspect' characteristics. In *AL (Serbia)* Lord Brown appeared to suggest, obiter, that age was a suspect characteristic, on a par with sex and race.[36] Age certainly seems to fit the test for a 'suspect' category set out by Reynolds in *RJM* in which he described protected characteristics as a set of concentric circles. The innermost circle contained characteristics which were 'innate, largely immutable, and closely connected with an individual's personality'; next come characteristics which, for

[33] ibid at 42
[34] note 26, above
[35] ibid at 58
[36] *AL (Serbia)* v *Secretary of State for the Home Department* [2008] UKHL 42 at 50: 'It involved no discrimination on any "suspect" ground. It was not sexist, nor racist, nor ageist.'

some, are 'almost innate' and for others may be acquired but which are, in all cases, important to the development of an individual's personality such as nationality, politics and religion; beyond this are characteristics which 'are more concerned with what people do, or what happens to them, than who they are.' The closer to the innermost circle the characteristic is, the more judicial scrutiny is called for. '[37] However, in the most recent consideration of the Gurkha pensions entitlements by the Court of Appeal, Kay LJ decided that 'stronger justification' would be required for discrimination on grounds of nationality than it was on grounds of age. Nationality was a suspect ground, whereas age was not. Arguments by the counsel for the appellants that age should be given 'suspect' status because 'it is innate, unalterable, closely connected with personal development and central to a person's individuality' were rejected as unsupported by domestic or Strasbourg authority.[38]

In the context of the Equality Act and EU anti-discrimination law, age has also been argued to be 'different' from other protected characteristics by the judiciary – thus explaining why justifications which would not be permitted in respect of other protected characteristics may be accepted in respect of direct age discrimination. Judicial arguments as to why age may be different from other 'suspect' or 'protected' characteristics can be summarised into – broadly – four categories, as follows:

First is the argument that age is different simply because the law – reflecting society - treats it differently. This was the view articulated by Advocate General Jacobs in *Lindorfer* where he explained that 'equality of treatment irrespective of sex is at present regarded as a fundamental and overriding principle to be observed and enforced whenever possible, whereas the idea of equal treatment irrespective of age is subject to very numerous qualifications and exceptions, such as age limits of various kinds, often with binding legal force, which are regarded as not merely acceptable but positively beneficial and sometimes essential.'[39] The different status of age is reflected in Directive 2000/78, which prohibits discrimination on a number of grounds including age and replicated by the Equality Act in implementing its provisions. The courts, therefore, have been able simply to accept that age discrimination is (at least sometimes) different from discrimination on other grounds, without the need to consider why. The difficulty with this approach is that the fact that age is treated differently by law does not tell us much about when direct discrimination can be justified.

[37] *R (RJM)* v *Secretary of State for Work and Pensions* [2008] UKHL 63 at 5
[38] *R (British Gurkha Welfare Society and Others) v Ministry of Defence* [2010] EWCA Civ 1098 at 11
[39] *Lindorfer* v *Council*, Case C227/04P, Opinion of Advocate General Jacobs Opinion delivered on 27 October 2005 at 85.

Without knowing why age is different, it is difficult to distinguish between the circumstances in which it is justified and those in which it is not.

Second is the argument that for some reason treating someone differently, or indeed even less favourably, because of age is somehow less demeaning than discrimination on other grounds. This view was expressed as follows by Lord Walker in *Reynolds*:

> 'Age is a personal characteristic, but it is different in kind from other personal characteristics. Every human being starts life as a tiny infant, and none of us can do anything to stop the passage of the years. As the High Court of Australia said (in a different context) in Stingel v The Queen (1990) 171 CLR 312 , 330: "the process of development from childhood to maturity is something which, being common to us all, is an aspect of ordinariness." There is nothing intrinsically demeaning about age. It may be disheartening for a man to be told that he cannot continue in his chosen job after 50, and it is certainly demeaning for a woman air hostess to be told that she cannot continue as cabin crew after the age of 40 (see *Defrenne v Société Anonyme Belge de Navigation Aérienne* (Case 43/75) [1976] ECR 455). But Mlle Defrenne was discriminated against on the ground of sex, not age.'[40]

The argument appears to be that ageing, and having a turn at being each consecutive chronological age (until we die), is something we all share (though not necessarily at the same time); and that distinctions made on this basis cannot affect us in the same way as distinctions made on the basis of characteristics that we do not share. It is not immediately clear why this should be so. It is obvious – as seen above - that the immutability of personal characteristics is one of the features which has had an important influence on judicial views as to the degree of scrutiny that is appropriate; and this argument about age suggests that it is the fact that age will change – even though we cannot choose to change it – that marks it apart. The reason age discrimination is judged to be less demeaning may also perhaps relate to the third category of argument which goes to the impact of the discrimination on the individual concerned.

The third category of argument is sometimes referred to as the complete life view argument. Lady Hale explained it as follows in *Seldon*:

> 'age is not "binary" in nature (man or woman, black or white, gay or straight) but a continuum which changes over time…this means that younger people will eventually benefit from a provision which favours older employees, such as an incremental pay scale; but older employees

[40] *Reynolds*, note 7 above, at 60

> will already have benefitted from a provision which favours younger people, such as a mandatory retirement age.'[41]

The suggestion is that no unfairness is created by the discrimination because – when judged over a lifetime – the same opportunities (and constraints) will have been available to all. This locates the wrong of discrimination firmly in the inequality it creates rather than in the act of making the distinction per se. Thus discrimination which does not create inequality can be justified. A stronger claim, also found in the jurisprudence on age discrimination in employment, is that age discrimination may be *necessary* to create equality – because, for example, without it older workers will have more than their fair share of employment opportunities at the expense of younger workers. This is sometimes called the 'fair innings' argument. While the evidence on which such claims are founded is contested,[42] the argument still carries significant weight with the judiciary. Neither the CJEU nor the UK courts have had any trouble accepting as legitimate aims those that promote 'intergenerational fairness.'[43]

The final argument is that the use of age as a proxy is (sometimes) able to make more accurate distinctions than is the case with other protected characteristics. Thus Advocate General Jacobs, again in *Lindorfer*, contrasted the use of sex and the use of age in drawing distinctions: 'Sex is essentially a binary criterion, whereas age is a point on a scale. Sex discrimination based on actuarial tables is thus an extremely crude form of discrimination, involving very sweeping generalisations, whereas age discrimination may be graduated and may rely on more subtle generalisations.'[44] This argument, again, appears to relate to the effect of using age as a substitute for other characteristics: while it will still amount to a 'bright line', the number of individuals who fall on the wrong side will be less than is the case for other characteristics.

These arguments will be evaluated in later chapters. For now, however, it is clear that, at least in the eyes of some of the judiciary, the nature of the characteristic which is used as a proxy or bright line is key to determining whether and when its use can be justified and the degree of judicial scrutiny or deference which is appropriate. This is true both under the Equality Act

[41] *Seldon*, note 19 above, at 4; See also the Opinion of Advocate General Kokott in *Association Belges des Consommateurs Test-Achats ASBL* v *Conseil des Ministres* (C-236/09) delivered on 30 September 2010 (at para. 50 and footnote 37) where she makes a similar point in relation to age related insurance premiums.
[42] See e.g. Department for Business, Innovation and Skills (2011) *Phasing Out the Default Retirement Age: Government Response to Consultation* (BIS, London) which concluded that the abolition of the default retirement age would not have negative impact on younger workers.
[43] See, for example, *Rosenbladt v Oellerking GmbH* [2011] CMLR 1011; *Fuchs and another v Land Hessen* [2011] 3 CMLR 1299; *Petersen v Berufungsausschuss für Zahnärzte für den Bezirk Westfalen-Lippe* [2010] 2 CMLR 830; *Seldon*, note 19 above.
[44] Note 39, above, at 84

(where, but for age, and a number of particular exceptions, direct discrimination cannot be justified) and under Article 14 of the ECHR where judicial interpretation has created a framework for application which hinges on the nature of the characteristic involved.

This will not be the only relevant factor however. Some uses of – even suspect – characteristics as proxies can be legally justified, whereas some uses of non-suspect characteristics cannot. The next two sections will identify some of the other considerations which come into play – in particular the purpose of the use of the characteristic (which will – normally – be an assessment of whether the aim is legitimate), together with a number of issues relevant to an assessment of proportionality, including the accuracy of the proxy, the availability of an alternative test, and the scope for exceptions in individual circumstances.

The purpose of the distinction – legitimate aims

Some aims are never 'legitimate.' Unsurprisingly, aims which are perceived to counter the purpose of anti-discrimination protection are not accepted as capable of justifying discrimination. Thus, for example, in *Reynolds* a sharp distinction was drawn between age distinctions which were drawn *in order to* suggest that one group (in this case those under the age of 25) were less valuable than older adults, and distinctions which were drawn simply in order to reflect statistical differences between the two groups. The former were forbidden whereas the latter were permitted. Likewise in *AL (Serbia)* Lord Hope noted that the absence of deliberate targeting (again, in this case, of young adults) was an important factor in assessing whether there had been a breach of Article 14: 'Deliberate discrimination will always risk intervention by the judiciary. But a difference in treatment of people outside the so-called suspect categories which is simply a by-product of a legitimate policy will not normally do so.'[45] It is not always easy to distinguish objectionable racist motivation from apparently rational behaviour, however.[46] Indeed, as the courts have noted in dealing with problems with the burden of proof in discrimination cases, perpetrators of discrimination may not always be aware of their own motives.[47] In addition, the statistical evidence upon which rational behaviour is based can of course reflect historical prejudice against a particular group, as well as serve to reinforce it.[48] The significance of the *cause* of a statistical

[45] *Al(Serbia)*, note 36, above, at 10
[46] See discussion of this problem in Moran, R. (2002) 'The Elusive nature of discrimination' 55 *Stanford Law Review* 2387
[47] *King v Great Britain China Centre* [1992] ICR 516
[48] See Moran, note 46, above.

correlation between members of protected groups and some other characteristic is discussed below, in the context of proportionality.

Positive Action

One area where the use of suspect characteristics as proxies is normally permitted – with limitations – is in the context of positive action. Thus under the Equality Act, and under the EU equality directives, treatment which would normally amount to direct justification is permitted where, among other things, its purpose is to redress disadvantage or underrepresentation attaching to the protected group. Thus the use of race or sex as a proxy for disadvantage is acceptable where the purpose of using the distinction is to remedy that disadvantage – particularly where that disadvantage exists as a result of past or continuing discrimination against member of the group.

Provisions explicitly permitting (limited) positive action are found in the EU Treaty[49] and in the anti-discrimination directives, as well as in the Equality Act. Thus Article 157 of the TFEU provides 'With a view to ensuring full equality in practice between men and women in working life, the principle of equal treatment shall not prevent any member state from maintaining or adopting measures providing for specific advantages in order to make it easier for the under-represented sex to pursue a vocational activity or to prevent or compensate for disadvantages in professional careers.' Similar provisions are found in each of the anti-discrimination directives. [50] The CJEU, after a few false starts, confirmed in *Marschall* that the scope of permissible positive action includes positive discrimination in the context of recruitment or promotion in the workplace.[51] Recognising that discrimination against women plays a significant part in matters of recruitment and promotion as a result, in particular, of stereotypical assumptions made about the choices women make as regards work and family, the Court noted that positive discrimination in favour of female candidates was permitted (subject to certain conditions) if it would serve to 'counteract the prejudicial effects on female candidates of the attitudes and behaviour described above and thus reduce actual instances of inequality which may exist in the real world.'[52] The key limitations on the scope of permissible positive action are that the candidate given preference must be equally well

[49] Treaty on the Functioning of the European Union ('TFEU').
[50] See Article 7 of Council Directive 2000/78, note 18, above; Article 5 of Council Directive 2000/43 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin; and Article 3 of Council Directive 2006/54 on the implementation of the principle of equal opportunities and equal treatment of men and women etc (recast).
[51] *Marschall v Land Nordrhein-Westfalen* [1998] IRLR 39 ECJ.
[52] ibid at 31.

qualified, and that employers must not have a rule which gives automatic priority to (in this case) one sex over another. The provision at issue in *Marschall* was permitted, where others had failed, because the employer retained the discretion to consider the individual circumstances of the applicants in each case. The ECtHR has likewise recognised that, not only should positive action be permitted under Article 14 in order to correct 'factual inequalities' between groups, but that failure to take special measures in respect of certain vulnerable groups may itself constitute unjustified discrimination under Article 14.[53]

The Equality Act permits forms of positive action within the bounds permitted by EU law. Section158 allows positive measures to redress disadvantage and lack of participation and to meet different needs, provided the means are proportionate (an example of positive action given in the Explanatory Notes to the Equality Act is a campaign to raise awareness among lesbians of the risk of cervical cancer).[54] Section 159 provides that in the context of recruitment or promotions, employers may treat applicants or employees more favourably on the basis that the group with which they share a protected characteristic suffer a disadvantage connected to the characteristic or have low levels of participation. Again, the treatment must be proportionate. In compliance with EU law, the section provides that the employer must not have a policy of treating persons who share the protected characteristic more favourably in connection with recruitment or promotion than persons who do not share it.[55]

There are two important points to note in relation to positive action as an example of statistical discrimination. First, there is no need for the individual taking advantage of the positive action provisions to show that they, personally, have been disadvantaged by past discrimination or membership of a protected group. Membership of the group is sufficient. Second, by contrast, consideration of the individual circumstances of each applicant by the employer *is* necessary. When faced with two equally qualified candidates, the employer must retain the discretion to allow individual circumstances to trump an inclination to discriminate in favour of the candidate who belongs to the disadvantaged (or underrepresented) group. It is not permitted to use sex – or another characteristic – as a bright line with no exceptions.

Positive discrimination or affirmative action remains controversial precisely because it treats group membership as a relevant factor in decision making, rather than assessing each

[53] *Belgian Linguistics Case (No 2)* [1979-80] 1 EHRR 252*; DH v Czech Republic* [2008] 47 EHRR 3*; Thlimmenos v Greece* [2001] 31 EHRR 15

[54] Explanatory Notes to the Equality Act 2010 at Section 158: examples.

[55] Equality Act 2010 S159(4)(b).

individual solely on the basis of their individual merits and needs - the 'wrong' of stereotyping identified by Lady Hale, above. Even where permitted, affirmative action can be (though is not always) subject to strict judicial scrutiny.[56] Supporters of affirmative action normally argue that positive measures are necessary to achieve substantive equality and that adherence to a strict equal treatment model - which prohibitions on direct discrimination reflect – fails both to understand the structural causes of discrimination and disadvantage and to provide a means of redressing inequalities between protected groups.[57] The debate on positive discrimination mirrors, to some extent, that which takes place in relation to intergenerational equality, thought there are important differences between them. Both concern the tension between – and attempts to reconcile – the need to address inequality between groups and the view that group membership should be irrelevant in determining how an individual is treated. However, not all differences in treatment because of age are characterised as a form of positive action, even where arguments about intergenerational equality are used to justify them; and arguments about intergenerational equality do not tend to hinge on the need to correct disadvantage created as a result of past discrimination against particular age groups, but rather the disadvantage which arises because one group has been alive, or economically active, for longer than the other. These issues are considered in more depth in the next chapter.

Aims other than positive action

Positive action aside, whether the purpose of discrimination is capable of justifying it normally depends on the protected characteristic involved. As seen above, where characteristics are suspect (or where direct discrimination cannot be justified under the Equality Act) direct discrimination is rarely permitted. Even matters of national security are not capable of justifying certain forms of discrimination. This is not because the aim is not legitimate – but because under no circumstances could the use of a protected characteristic as a proxy amount to a proportionate means of achieving it. Thus De Schutter and Ringelheim argue that, although the law is still developing, it is reasonably clear, following *Timishev* that racial profiling is prohibited by the ECHR even if a statistically significant relationship can be established between a particular ethnic or racial group and the activity the authorities are

[56] Fredman notes that in the US strict scrutiny is applied to affirmative action measures involving race: *Adarand v Pena* 515 US 200, 115 S Ct 2097 [1995], though not to those involving sex: *United States v Virginia* 518 US 515 [1996]. See Fredman, S. (2011) *Discrimination Law* (2nd Edition) (OUP, Oxford).
[57] See, for example, discussion in Fredman S, *Discrimination Law*, ibid.

concerned to prevent.[58] On the other hand, where the relevant characteristic is non-suspect, simple administrative convenience is normally deemed sufficient to justify its use as a proxy (provided that the use of the proxy to achieve this is also proportionate.)

In 2010, the CJEU had a rare opportunity to consider whether there were circumstances in which direct sex discrimination could be justified. In *Test Achats* the Court of Justice was asked to review the compatibility of Directive 2004/113 EC (regulating sex discrimination in the provision of goods and services) with one of the fundamental rights of EU law – the prohibition on sex discrimination. Specifically, the challenge was to Article 5(2) which provided that member states may (at least temporarily) continue to permit differences related to sex in respect of insurance premiums and benefits where sex was a determining risk factor and one that could be substantiated by relevant and accurate actuarial and statistical data. The defendant insurance company argued that their purpose in using statistical data based on sex to calculate premiums was to avoid increasing premiums for all. Advocate General Kokott – with whom the court agreed - argued that although there was nothing wrong in principle with using proxies in the calculation of risk, using *sex* as substitute criterion in this way was simply incompatible with the principle of equal treatment and inappropriate in a Union which had declared respect for dignity, equality and non-discrimination. Aside from situations where it could be established 'with certainty' that there are relevant differences between men and women, positive action was the only reason to justify sex discrimination. No other purpose could do so and 'purely financial considerations, such as the danger of an increase in premiums for a proportion of the insured persons or even for all of the insured persons, do not in any event constitute a material reason which would make discrimination on grounds of sex permissible.'[59] Interestingly, she drew a distinction between age and sex here, suggesting that as age is a characteristic that changes, the reasons for prohibiting the use of sex as a substitute criteria in the calculation of insurance risk would not necessarily apply to age.[60]

Age and legitimate aims

The kinds of aims which may be legitimate in justifying direct age discrimination in the context of the labour market are constrained to some extent by the Framework Directive[61] which sets out a (non exhaustive) list of permissible aims in Article 6: 'Member States may

[58] De Schutter, O. and Ringelheim, J. (2008) 'Ethnic Profiling: a Rising Challenge for European Human Rights Law' *Modern Law Review* 71(3) 358-384.
[59] *Test-Achats*, note 41, above, at 68.
[60] ibid, at 50.
[61] Note 18, above.

provide that differences of treatment on grounds of age shall not constitute discrimination, if, within the context of national law, they are objectively and reasonably justified by a legitimate aim, including legitimate employment policy, labour market and vocational training objectives, and if the means of achieving that aim are appropriate and necessary.' In *Seldon* the Supreme Court considered how far this provision should limit the aims which are capable of amounting to 'legitimate aims' under Section 13 of the Equality Act. Their conclusion was that, unlike indirect discrimination which can be justified by aims related to the business needs of the individual employer, direct age discrimination by employers can be justified only by aims of a public interest nature, which are consistent with the social policy aims of the state.[62] Aims which are purely individual and particular to the situation of the employer are not legitimate, although it is not necessary for an employer to show that their own motives in introducing discriminatory measures were concerned with matters of public interest. The Court accepted that employers will act in their own interests - it is sufficient if these interests are consistent with wider social policy aims.

In practice, as Sargeant notes, certainly in the jurisprudence of the CJEU it is rare for a measure which discriminates on grounds of age to be found not to be justified because the aim is not legitimate. A wide range of aims have been found to accord with the broader social policy requirements, including those relating to intergenerational equality, administrative convenience and protection of the dignity of the individual older worker. Challenges to discriminatory measures have been more likely to be successful on the ground that the measure in question is not proportionate.[63]

Proportionality

If a legitimate aim is established, the court will need to decide whether the use of the particular characteristic as a proxy is a proportionate means of achieving that aim. It will be remembered from chapter one, that the courts are not always consistent in their approach to the proportionality analysis and a number of variants of the test exist. With this caveat in mind, it is possible to identify a number of features that case law suggests may be relevant to determining whether the use of a particular proxy is proportionate. These include the accuracy of the proxy and – related – the impact on those excluded; the cause of any statistical correlation between the characteristic used as a proxy and the need, risk or capacity

[62] Note 19, above, at 55.
[63] Sargeant, M (2010) 'The default retirement age: legitimate aims and disproportionate means' *Industrial Law Journal* 39(3), 244-263.

for which it stands as a proxy; the availability of an alternative – less discriminatory - test for that need, risk or capacity; and whether there is scope for considering whether an exception to a rule should be made in the case of a particular individual.

The accuracy of the proxy

It will be remembered that, in *Roma Rights,*[64] the accuracy of the particular stereotype was deemed to be irrelevant to whether its use was justified. Outside the strict confines of Section 13 of the Equality Act, however, it is clear that the accuracy of the proxy is sometimes a consideration relevant to justification - although there is no clear threshold for the minimum level of accuracy required. The less accurate the proxy, the more people are likely to be on the 'wrong side' of the line and excluded from access to the benefit in question. Along with the nature of any hardship caused - which will, to a large extent, depend on the nature of the benefit to which access is denied – the accuracy of the proxy will be one of the considerations relevant to balancing the aim of the measure against the impact on those affected.

Clearly where the proxy is wholly inaccurate, the test of proportionality should be difficult to satisfy. Beyond this, it seems that – at least where non suspect characteristics are involved – the threshold of accuracy required to satisfy the demands of proportionality may not be difficult to meet. Indeed, as has already been noted, the fact that most bright lines are by nature rather rough and ready does not deter the courts from permitting their use.[65] In *Reynolds*[66] a low threshold of accuracy was required for the use of the age of 25 as a proxy for those who were (among other things) likely to have lower living costs and thus could be paid jobseekers allowance and then income support at a lower rate. While noting that any age limit was likely to prove arbitrary Lord Hoffmann held that all that was required for justification was that the distinction chosen 'should reflect a difference between the substantial majority of the people on either side of the line.'[67] In addition it is apparent from a number of cases – particularly cases concerning age discrimination - that courts are often willing to accept that a characteristic is a suitable proxy without a significant investigation into its accuracy. Thus, for example, in *Petersen* and *Kukukdeveci*, two age discrimination cases considered by the Court of Justice, age was argued to be a good proxy for an individual's being able to practice safely as a dentist and for having personal and

[64] Note 6, above.
[65] See, e.g. *Humphreys v Revenue and Customs Commissioners* [2012] UKSC 18; *AL (Serbia)* note 36, above.
[66] Note 7, above.
[67] ibid at 51

occupational flexibly and mobility.[68] While the discrimination was found not to be justified (in some respects) in both cases, this was not because the court appeared to have been troubled by the fact that the stereotypes or proxies were in any way likely to be inaccurate. Rather, in *Petersen*, the fact that private dentists were allowed to continue practicing beyond the age limit for publically listed dentists suggested that the restriction was not necessary in relation to *one* of the governments stated aims (public safety), although the use of the proxy was proportionate in other respects; in *Kukukdeveci* there was no real link between the means and the stated aim.

On the other hand, in *Hockenjos*, a case this time involving indirect rather than direct discrimination but a 'suspect' characteristic – sex - the discrimination caused by the use of a bright line rule was held not to be justified, partly as a result of the number of individuals who would fall on the 'wrong side' of the line and the impact on the rule upon them. Here, majority residence (statistically more likely to be granted to the mother) was used to determine which of separated parents should be entitled to additional financial assistance with childcare costs - majority residence was used as a proxy for financial need. In upholding the claim of indirect discrimination the court noted that it was significant that this was not a case where – although the rule resulted in fairness in the majority of cases - the unfairness caused as a result of the bright line was found only 'at the margin in a few unfortunate but untypical cases' but was found in a significant minority of cases.[69] This was unacceptable.

The accuracy of the proxy as a substitute criterion must of course be assessed by reference to the aims of the party using it. In *AL (Serbia)*, the Home Office had instigated a one-off exercise granting indefinite leave to remain in the UK to those who met certain eligibility criteria. The primary aim of the exercise, accepted by the Court, was to clear the administrative backlog and the eligibility criteria therefore targeted those whose applications were likely to be among the most complicated to process – and included those with families in the UK who also met other conditions. Given that applications from those who had entered the UK without family tended to be administratively easier, quicker, and cheaper to process, these applicants were excluded from the exercise. The claimants argued that this was direct discrimination on grounds of lack of family ties. Lady Hale, giving the leading judgment, considered that the discrimination could be justified as there was good evidence that lack of family ties (not a suspect characteristic) was a good proxy for administrative simplicity.

[68] *Petersen*, note 43, above; *Kucukdeveci v Swedex GmbH & Co KG* [2010] 2 CMLR 33.
[69] *Hockenjos v Secretary of State for Social Security* [2004] EWCA Civ 1749 at 43.

However, she noted that had the primary aim of the policy been one of compassion rather than administrative efficiency, then the use of the rule would be unlikely to have been found to be justified. For while there certainly were compassionate grounds for permitting those with family relations to remain, there were equally compassionate grounds for treating those with no family ties in this way. Being without family was a good proxy for the administrative simplicity but a poor proxy for the (lack of) need for compassionate treatment.[70]

In *Test Achats*, as was seen above, the use of sex as a proxy for insurance risk was rejected as incompatible with the principle of equal treatment. In her opinion, Advocate General Kokott also made some remarks on the nature of statistical discrimination generally. Statistical correlation between a protected group and some other characteristic, she argued, does not necessarily reflect a relevant difference between those inside and those outside the group. Correlation does not mean cause. The fact that women drivers, statistically, make less claims does not mean they make less claims because they are women. Similarly differences in life expectancy between men and women may not be down to innate biological difference but to historic differences in life choices which have now changed or are changing. In her opinion even biological difference between the sexes (such as pregnancy) is not *necessarily* sufficient to justify different treatment. Mere statistical association is certainly not. [71]

Thus - in Kokott's view - substitute criteria or proxies, derived from statistics, should be treated with caution to ensure that they reflect genuine underlying differences between those they seek to distinguish. There is, presumably, particular need for caution where statistical differences may reflect past discrimination - something which has been raised as a matter of concern in a number of cases.[72] Although Kokott distinguished age from sex in the same opinion, her comments on statistics may be equally applicable to the use of age as a proxy. Indeed, if we accept her assertion that a difference in treatment can only be justified where it can be established with certainty that there are relevant differences between groups, the use of age as a proxy may be *more* difficult to justify than is the case for other characteristics. For there can never be a relevant difference between two individuals on either side of an age line. Even if it can be established with certainty that there are relevant differences between 18 and 80 year olds, this will (one imagines) never be possible with two individuals who are a day apart in age.

[70] *AL (Serbia) v Secretary of State for the Home Department* [2008] UKHL 42
[71] Note 41, above.
[72] See, e.g. *Markin* v *Russia* [2013] 56 EHRR 8

Availability of an alternative/individual test

Certainly where a 'necessity' version of the proportionality test is used, the existence of a less discriminatory alternative to the use of the chosen proxy may signal that the measure in question is not proportionate. An alternative measure may include using an alternative substitute criterion as a proxy, or indeed testing each individual to see whether those concerned do indeed possess the necessary characteristics to qualify for whatever benefit is at stake. However, as has been seen already, in applying the proportionality test in the cases concerning the use of age proxies, there is little evidence that the CJEU considers the availability of an alternative test to be fatal to the proportionality of a measure. There was no suggestion, for example, in *Petersen*, that the use of age to determine when a dentist was no longer safe to practice could have been replaced by an individual fitness to practice test, administered to all dentists.

In relation to Article 14, it has been suggested that 'necessity' is neither necessary nor sufficient but instead is simply one of the 'tools of analysis in examining the cogency of the reasons put forward in justification of a measure'.[73] At least in relation to non-suspect categories, it seems, the existence of a less discriminatory alternative does not mean a measure will fail the proportionality test; and the administrative workability and cost of alternatives are certainly relevant. *Bibi*, for example, concerned the application of a language test to applicants for long term residence. Nationality was used as a proxy to determine who should be exempt from the test and who should not – nationals from English speaking countries were exempt. The possibility of an alternative approach, including individual testing, was considered. The Court held that 'it would be absurd to suggest that a person should have to undergo a test to prove that he or she meets the language requirement in order that he or she should be entitled to benefit from an exemption from the requirement to undergo a language test… in this context, it is administratively sensible and permissible to draw relatively 'broad' or 'bright' lines in terms of selecting those who can be considered as already sufficiently meeting the requirement to justify being exempted from the provision. What is necessary is that the particular 'bright line' adopted be a rational one.'[74] Likewise, even where a feasible alternative test is conceivable, the cost and administrative

[73] *R (on the application of Wilson) v Wychavon DC* [2007] EWCA Civ 52.
[74] *R (Bibi) v Secretary of State for the Home Department* [2013] EWCA Civ 322 at 42 citing Beatson, J. at first instance [2011] EWHC 3370 (Admin) at 132.

inconvenience involved may incline the court to decide that a failure to choose the alternative was not disproportionate.[75]

On the other hand, the *unavailability* of an alternative test is clearly insufficient, on its own, to justify the use of a suspect characteristic as a proxy.[76] And in *Test Achats*, again involving a 'suspect' characteristic, the increased cost and inconvenience – and even the consequences of this for consumers – of finding another method to calculate actuarial risk was not enough to lead the court to find the use of sex as a proxy proportionate.[77]

Interestingly, in *Seldon*, age was used as a proxy, among other things, for declining capacity. The argument was that the mandatory retirement age in question was justified as a means of preserving the dignity of older workers by preventing their dismissal for incapacity. There was a notable and somewhat frustrating lack of discussion on this issue in the case, which makes conclusions harder to draw. However, it was accepted that age should be used as a proxy for declining capacity in order to *avoid* an actual capacity test. The purpose of the age limit was to protect individuals from this assumed humiliation. Thus, the nature of the alternative test was a deemed a reason to find the measure proportionate.

Finally, it is worth mentioning Genuine Occupational Requirements (GORs) in this context. These provisions, found in both EU law and in the employment provisions of the Equality Act, provide that employers may require job applicants to possess certain protected characteristics if it is an occupational requirement, and applying the requirement is a proportionate means of achieving a legitimate aim. The application of GORs does not normally involve the use of protected characteristics as proxies for others but instead catches situations where it is possession of the protected characteristic itself that is integral to the job in question. Examples given in the Explanatory Notes to the Act include the need for an actor to be of a particular sex or colour or age or for a public changing room attendant to be of a particular sex.[78]

However, in *Wolf*[79] the Court of Justice suggested that the Genuine Occupational Requirement provision in the Framework Directive does permit the use of protected

[75] *R (on the application of Hooper) v Secretary of State for Work and Pensions* [2002] EWHC 191 (Admin).
[76] Note 26, above.
[77] Note 41, above.
[78] Note 54, above, at Schedule 9, Part 1: examples.
[79] *Wolf v Stadt Frankfurt am Main* [2010] 2 CMLR 32.

characteristics as proxies. The wording of the relevant Article in the Directive is different from that in the Equality Act, providing that

> 'Member States may provide that a difference of treatment which is based on a characteristic **related to** any of the grounds referred to in Article 1 shall not constitute discrimination where, by reason of the nature of the particular occupational activities concerned or of the context in which they are carried out, such a characteristic constitutes a genuine and determining occupational requirement provided that the objective is legitimate and the requirement is proportionate.'[80]

Thus the characteristic which is the occupational requirement need only be related to a protected characteristic, rather than actually be a protected characteristic, suggesting the use of protected characteristics as proxies for other qualities is permissible.

In *Wolf* the requirement in question was a minimum recruitment age for fire fighters. The concern of the employer was that new recruits be able to maintain the required level of fitness to work as an operational firefighter for a minimum of 15 years after joining. The Court were satisfied, on the basis of the evidence produced by the German Government, that physical fitness declines with age, that it was unlikely that most individuals would have the required level of fitness beyond the age of 45-50, and that therefore the use of a minimum age requirement of 30 for recruitment was proportionate. Age could be used as a proxy for physical fitness. The possibility of an alternative method of testing for physical fitness was not considered. It is true that the employer's requirement here was that recruits be of a certain level of physical fitness 15 year in the future – something which it may be very difficult to test for at the time of application. However the availability or otherwise of an appropriate alternative test does not appear to have been a relevant consideration at all. The boundaries of the use of protected characteristics as proxies in this context are therefore unclear. It is difficult to know whether – had the requirement been simply for a particular level of physical fitness at the time of recruitment, for example, – the application of age as a GOR would have been permitted by the Court or whether the availability of an alternative option of testing each applicant for physical fitness would have rendered the application of the age requirement disproportionate.[81]

Exceptions

[80] Framework Directive, note 18, above, Article 4(1) (my emphasis).
[81] For a discussion of this case see Pitt, G. (2011) 'Are occupational requirements genuinely necessary?' *Contemporary Issues in Law* 11(1), 1-18.

A final important consideration is that of exceptionality. If the problem of using a characteristic as a proxy is that it treats individuals not as individuals but as members of groups, can the possibility of making exceptions to such rules for individuals – on consideration of their own particular circumstances - make the use of the proxy proportionate?

The possibility of an exception being made has certainly been a relevant consideration in a number of cases. In *AL (Serbia)* it was one of the features which led the Court to conclude that the government policy of using family status to determine eligibility was justified. The measure was proportionate because, among other things, 'it permitted compelling claims by those falling outside the policy to be recognised and accommodated.'[82]

On the other hand, however, in *Seldon* the Supreme Court were asked to decide whether, in addition to having to justify a general rule which discrimated directly on grounds of age, an employer had to justify the application of that rule to the particular applicant. The applicant argued that even if the use of the mandatory retirement age was in general a proportionate means of achieving a legitimate aim, its application to him could not be justified. The Court held, however, that there was no need for employers to justify the application of a rule to a particular individual. Lady Hale agreed that 'where it is justified to have a general rule, then the existence of that rule will usually justify the treatment which results from it.' Requiring employers to justify the application of rules to individual employees would, she argued, normally negate the value of having a rule in the first place.[83] As a result, therefore, it seems unlikely that employees will be able to argue that, in their particular case, age is *not* a good proxy for some other characteristic, even if statistics indicate that it is for the majority.

Conclusion

The chapter has drawn out some of the considerations which govern judicial responses to statistical discrimination. The picture that emerges is neither clear nor consistent. However, leaving aside constraints imposed on the judiciary by the relevant legislation, a number of factors can be identified as being particularly important in judicial assessment of when the use of certain characteristics as proxies can be justified. First is the nature of the characteristic

[82] *Al (Serbia)*, note 36, above, at 3; See also *R v Entry Clearance Office ex parte Abu-Gidary* [2000] 2000 WL 741931 QBD, where the application of stereotypical assumptions about those residing in Sudan by immigration authorities was deemed to be an acceptable starting point, and hence not irrational, provided that the immigration officers were prepared to consider evidence that the circumstances of individual applicants may not conform to these stereotypes.
[83] Note 19, above, at 65 and 66.

itself; second is the purpose of its use as a proxy; and third is the accuracy of the proxy and the availability of alternatives to its use, including the possibility of making exceptions to the relevant rule in particular cases. These factors are revisited in chapter eight when the relationship between dignity and age discrimination is explored in depth. First, however, the next chapter takes the opportunity to examine in more detail two of the arguments that have been raised by courts to justify treating age differently from other protected characteristics – the complete life view and fair innings arguments.

CHAPTER FOUR: THE 'COMPLETE LIFE VIEW' AND 'FAIR INNINGS' ARGUMENTS

Introduction

It was seen in the last chapter that in cases where age discrimination has been considered by the courts, one response has been to distinguish age from other personal characteristics. Treatment on grounds of age has been held to be justified where treatment on grounds of, for example, sex, would not because 'age is different.' A number of arguments for making this distinction, evident in the case law, were outlined in the previous chapter. These were that age stands as a more accurate proxy than other characteristics; that age is less demeaning than other characteristics; that age discrimination does not create inequality in the same way as discrimination on other grounds because equality is to be judged over a lifetime rather than at a particular moment in time (the 'complete life view'); and that age discrimination is necessary to redress intergenerational inequality (the 'fair innings' argument). The last two of these - the complete life view and fair innings arguments - have been subject to considerable debate in the literature on the use of age in the allocation of health care, both in health economics and political philosophy. This chapter now explores those arguments in more detail.

The rationing context

The use of complete life view and fair innings arguments by courts and policy makers is seen most often in the employment context where issues such as mandatory retirement, pensions policy and youth unemployment have raised difficult questions about how to achieve justice between generations.[1] Thus, for example, and as seen in chapter three, mandatory retirement has been justified as a legitimate means to ensure opportunities in the workplace for younger generations and defended as being a policy which does not disadvantage older workers who will once have benefited from the same provisions themselves.[2] In the health care context, however, the argument for explicit age-based rationing is conspicuous in its absence from the policy debate. Williams notes, however, that support for the view that the young should be

[1] See, for example, Lazear, E. (1979) 'Why is there mandatory retirement' *The Journal of Political Economy* 87(6) 1261-1284; see also discussion in Issacharoff, S. and Worth Harris, E. (1997) 'Is age discrimination really age discrimination? The ADEA's unnatural solution.' *New York University Law Review* 72(4) 780-840.
[2] *Seldon* v *Clarkson, Wright and Jakes (a Partnership)* [2012] UKSC 16.

prioritised over the old may be evident at the level of clinical policymaking, when individual clinicians need to prioritise between different needs.[3] It was seen in chapter two that there is considerable evidence of the covert use of age to determine access to a range of interventions, in addition to examples of its explicit use. Williams suggests that 'for the professionals what may be in their minds may be mostly old people's impaired capacity to benefit from health care. But I strongly suspect that some variant of the fair innings argument also underlies such views, and this is especially likely to be the case among the general public. When the views of older respondents in such surveys have been reported separately, they too give priority to the young over themselves.'[4] That the general public support some version of fair innings rationing is supported by a 2012 study by Dolan and Tsuchiya which demonstrated public support for sacrificing some overall health gain in the population in order to reduce inequalities associated with life expectancy. The authors concluded that the trade – offs chosen by the public 'are the direct result of the general public's concern for a 'fair innings' in overall health terms along the lines of that put forward by Williams.'[5] Williams' account of the fair innings argument is explored below.

Notwithstanding its absence from the policy debate, there is an ongoing and lively debate in the academic literature about whether and why rationing by age of health care resources is needed and is justifiable. It is important to note that much of this debate takes place against an assumption that health resources are limited and must be rationed; and an assumption that health resources are consumed disproportionately by older people, and that the ageing population will therefore place yet more pressure on health budgets, resulting in cuts elsewhere should the medical needs of older people continue to be met in full. Both of these assumptions about the need for rationing are contested.

Not everyone agrees that health care rationing is a necessity. As Grimley Evans puts it, 'health care resources in Britain are limited, but only because the government limits them.'[6] However, there is, Herring suggests, a widespread consensus that it is not feasible for a publically funded system to meet every health care need which may arise.[7] Health related

[3] Williams, A. (1997) 'The Rationing Debate: Rationing health care by age: The case for' *British Medical Journal* 314: 820.
[4] Ibid at 822.
[5] Dolan, P. and Tsuchiya, A. (2012) 'It is the lifetime that matters: public preferences over maximising health and reducing inequalities in health.' *Journal of Medical Ethics* 38 571-573 at p. 573.
[6] Grimley Evans, J. (1997) 'The Rationing Debate: Rationing health care by age: The case against' *British Medical Journal* 314:822.
[7] Herring, J. (2012) *Medical Law and Ethics* (Oxford, OUP).

spending is predicted to continue to outstrip economic growth.[8] Combined with increases in demand for health care as a result of a number of factors, including improvements in medical technology and population growth, this suggests, as Newdick argues, that 'supply and demand in health care will never reach equilibrium; on the contrary, demand will continue to exceed supply and the debate as to rights to health care entitlements will become more intense.'[9]

Increasing pressure on the health and social care budget is often linked to the ageing population amidst a well-publicised and controversial policy debate about how these pressures are to be met. By 2035 the percentage of the UK population over the age of 85 is projected to rise to 5% (from 2% in 2010) and the percentage over 65 to 23% (from 17% in 2010.)[10] According to NHS England in 2013, the over 65s accounted for almost two thirds of hospital admissions and nearly 70% of emergency bed use with older people also much more likely to spend longer in hospital and to be later readmitted;[11] and health spending is also affected by lack of social care provision, with older people sometimes described in the press as 'bed blockers.'[12] However, the reason for this association between age and health related spending is disputed among health economists and others. There are three factors in particular which suggest the picture may be much less straightforward than one where increased life expectancy necessarily generates increased pressure on the health budget. First, increased life expectancy (other than through its impact on the size of the population as a whole) does not itself increase the demand for health care. What matters is the proportion of that increased life span which is lived in poor health. Recent statistics suggest that, in the UK at least, healthy life expectancy is rising at least in line with overall life expectancy and indeed the gap appears to be narrowing, meaning that there has been a very slight reduction in the years of ill health people can expect, rather than an increase.[13] Second, much research suggests that it is

[8] International Monetary Fund (2015) *Now is the Time; Fiscal Policies for Sustainable Growth* (IMF, Washington DC).
[9] Newdick, C. (2005) *Who Should We Treat? Rights, Rationing and Resources in the NHS* (2nd Edition) (OUP, Oxford) chapter 1.
[10] ONS (2012) *Population Ageing in the United Kingdom, its Constituent Countries and the European Union* (ONS, London).
[11] NHS England (2013) *The NHS Belongs To The People* (NHS England, Leeds).
[12] Merrick, Jane 'NHS Feels the strain as hospital bed-blocking by elderly patients hits record levels' *The Independent* (London, 22 March 2015) available at http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-feels-the-strain-as-hospital-bedblocking-by-elderly-patients-hits-record-levels-10125422.html (accessed October 2015)
[13] ONS (2015) *Sustainable Development Indicators, July 2015* (ONS, London); Grimley Evans has argued that 'longevity achieved by the right mechanisms will reduce the costs of care in later life.' In Grimley Evans, J. (2003) 'Age Discrimination: Implications of the Ageing Process' in Fredman, S. and Spencer, S. (2003) (ed.'s) *Age as an Equality Issue* (Hart, Oxford)

dying - at whatever age that may occur - rather than living longer, that incurs the most health related expenditure and that the correlation between age and health expenditure simply reflects the fact that most people die when they are old. Breyer et al. found that population ageing accounts for only a small fraction of annual growth rate of health care expenditure once the costs of dying were controlled for.[14] Interestingly, the same report notes that the rise in longevity in itself appears to have fuelled demand for life-prolonging medical care. Third, any full account of the relationship between ageing and health spending needs to take account of the economic contribution of older people, in relation to, among other things, both paid work and unpaid care. Spijker and MacInnes, for example, argue that an increase in healthy life expectancy 'makes these older people "younger," healthier, and fitter than their peers in earlier cohorts' and important economic contributors.[15] The estimate of the economic contribution to the UK economy of unpaid carers, very many of whom are in their seventh or eighth decades,[16] was in the region of £119 billion per year in 2014, calculated as the replacement cost of the unpaid care,[17] and is greater than the total projected expenditure on the NHS for 2015/16.[18]

Bearing in mind these caveats, the rest of this chapter now explores the complete life view and fair innings arguments for age based rationing of NHS resources and some of the main objections to them. In particular, it will identify reasons why the complete life view of equality may not be sufficient to eliminate concerns about the use of age to determine access to health care.

Ageing and the Complete Life View of Equality

One consequence of the addition of a prohibition on age discrimination to the equality law framework is that it focusses attention on a temporal dimension to equality. When considering whether two individuals have been treated equally in some respect, a decision

[14] Breyer, F., Costa-Font, J. and Felder, S. (2010) 'Ageing, Health and Health Care' *Oxford Review of Economic Policy* 26(4) 691-712; see also Werblow, A., Felder, S. and Zweifel P. (2007) 'Population ageing and health care expenditure: a school of 'red herrings'?' *Health Economics* 16(10) 1109-1126 and Bech, M. and Terkel, C. (2011) 'Ageing and health care expenditure in EU-15' *The European Journal of Health Economics* 12(5) 469-478; for a contrary view see Colombier, C and Weber, W (2011) 'Projecting health-care expenditure for Swizerland: further evidence against the 'red-herring' hypothesis' *International Journal of Health Planning and Management* 26(3) 246-63.
[15] Spijker, J. and MacInnes, J. (2013) 'Population ageing: the time bomb that isn't?' *British Medical Journal*:347.
[16] Carers UK (2015) *Caring into Later Life* (London: Carers UK).
[17] Carers UK (2014) *Facts About Carers – Policy Briefing May 2014* (London: Carers UK).
[18] NHS Confederation (2015) *Key Statistics on the NHS* available at http://www.nhsconfed.org/resources/key-statistics-on-the-nhs (accessed August 2015).

must be made whether to compare their treatment at a particular moment in time (sometimes called synchronic equality), or their treatment across the course of their complete lives (known as diachronic or complete life equality). Anti-discrimination statutes generally require the assessment of whether there has been *prima facie* direct discrimination - 'less favourable treatment because of a protected characteristic' - to be made at a particular moment in time. Synchronic equality is what matters here. Less favourable treatment today is not generally seen as being in some way cancelled out or compensated by favourable treatment last week or the promise of better treatment tomorrow. Thus, if my health insurance premium is higher because I am over 40 than it would be if I was under 40, the relevant comparison is with the premium I am charged, today, and that charged to an individual under the age of 40. It doesn't matter that I was once charged the lower amount or that they will one day be charged the higher. I have been less favourably treated because of my age – prima facie directly discriminated against.

However, once less favourable treatment because of a protected characteristic is established, the courts are required – in the case of age - to consider whether the treatment is justified; and it is in assessing whether this less favourable treatment may be *justified* that courts, as we have seen, have appealed to the notion of complete life equality. Dennis McKerlie defines the complete life view ('CLV') as the normative principle "that different people's share of resources, or welfare, should be equal when we consider the amounts of those things that they receive over the complete course of their lives."[19] If a complete life view is taken then age discrimination, or at least some instances of it, can be argued to be distinct from discrimination on other grounds. Using age as a criterion for determining access to various goods, provided this is done consistently over time, appears to create no diachronic inequality, because over the course of a lifetime we will all be eligible for the same benefits and subject to the same burdens. Less favourable treatment because of age today is only part of this story because it is compensated by the more favourable treatment we received in the past or will receive in the future; and so, across the complete course of our lives, we will not have been treated unequally with others. Indeed on this view, as Cupit notes, age discrimination appears to be simply a matter of taking turns.[20]

Although intuitively appealing, there are a number of difficulties with an appeal to the complete life view of equality, both empirical and conceptual. First, the notion of complete

[19] McKerlie, D. (1989) 'Equality and Time' *Ethics* 99(3) 475–491.
[20] Cupit, G. (1998) 'Justice, Age, and Veneration' *Ethics* 108(4), 702-718.

life equality relies on the idea that we will all enjoy the same provision (or denial) of benefits, opportunities or services over a lifetime; all will, at the end of their lives, have been treated equally across the life course and what we are denied because of our age today will not matter as we will be compensated by having been eligible for it in the past or becoming eligible for it in the future.[21] However it is obvious that not everyone is able to take advantage of earlier or later compensation.[22] We may die before we have the opportunity; and even if we do not, circumstances may mean that we are unable to take advantage of the benefits offered to us at one stage in our lives in order to compensate for the lack of benefits available at other times. In addition, the experiences of different generations may also be difficult to compare. Changes in law (including anti-discrimination law), policy, economy, culture and expectations, knowledge and so on will all mean that a particular generation – or groups within that generation - may have been more or less able to benefit from opportunities currently available to younger generations. Thus, for example, in the health care context, older generations will not have had, when younger, the benefit of recent advances in medical technology and pharmacy.[23]

The problem with the compensation model is particularly evident if one considers the provision of goods and services which are intended to meet basic needs. Certain resources or services will only be valuable to me if the time when they are provided coincides with the time I am in need of them. If I need something today, it doesn't matter that I can have it tomorrow when I no longer need it, or could have had it yesterday when I did not need it. It is difficult to conceive of something I don't need now being able to compensate me, in a meaningful way, for having lacked it when I did need it. Those whose needs coincide with provision are better off - on a complete life view - than those whose needs arise, inconveniently, at the wrong time. Consider health care needs for example. The cervical cancer screening programme in England and Wales currently invites women between the ages of 25 and 65 for screening.[24] These limits are chosen, in part, to coincide with the

[21] For advocate of this view of compensation see Nagel. T (1979) *Mortal Questions* (CUP, Cambridge) discussed in McKerlie, D. (2001) 'Justice Between the Young and the Old' *Philosophy and Public Affairs* 30(2) 152-177.

[22] Fredman also makes this point in (2003) 'The Age of Equality' in Fredman and Spencer (2003) note 13, above.

[23] See e.g. Grimley Evans, J. (2003) note 13, above, where he argues that the differences between health status of members of different generations will often be a result of generational experiences rather than of chronological age.

[24] http://www.cancerscreening.nhs.uk/cervical (accessed October 2015)

prevalence of the disease, for which age is deemed to be a reasonable proxy.[25] Imagine I develop cervical cancer after 65 and it remains undetected until treatment is likely to be ineffective, whereas my comparator develops cancer during that age band, is detected and successfully treated. Even though I was *offered* the same thing at the same age as my comparator, I *received* something less valuable because it was offered to me when I didn't need it and was not in a position to benefit from it. It is simply not the case that such distinctions create no relative disadvantage.

The complete life view of equality has nonetheless been developed by a number of influential egalitarian thinkers and advocated as the right way to achieve an *a priori* just distribution of resources. Both Dworkin and Daniels, for example, advance (different) conceptions of equality which accept that a fair distribution of resources may involve an uneven distribution over the lifecourse.[26] Daniels has developed and applied a variant of the complete life view approach – which he calls the 'prudential lifetime account' - to the problem of allocation of limited health care resources. Instead of characterising competition for limited resources as including competition between younger and older generations, Daniels argues that we should see the problem as one of how a prudent individual (behind a Rawlsian veil of ignorance) would choose to allocate a fixed set of health care resources across their lifetime. The goal of prudence, according to Daniels, is to make each complete life as good as it can be. As prudent individuals, then, we may choose an uneven distribution or resources across the course of our lives so as both to maximise the resources we have available to us at certain key stages of our lives and to reflect the likely incidence of certain health needs and diseases at different ages. A prudent planner may, for example, choose to maximise health care resources available to them earlier in their lives to coincide with the most likely opportunities to develop a career and bring up children, rather than to save the lion's share of available resources to spend on extending life in very old age. Institutional arrangements reflecting such prudential planning

[25] Although, as was discussed in chapter two, evidence regarding the appropriateness of these age limits is disputed.

[26] Daniels, N. (1985) 'Am I My Parents' Keeper?' in *Just Health Care* (CUP, Cambridge); Dworkin, R. (2000) *Sovereign Virtue: The Theory and Practice of Equality* (Harvard University Press, Cambridge MA) Dworkin incorporates the complete life view in his auction model of distributive justice which requires us to imagine each individual, armed with equal resources, bidding for a bundle of goods at an auction, such that at the end of the auction each individual is satisfied with their bundle of goods and does not envy another's. He stresses that this 'envy test' must apply diachronically: 'If we look for envy at particular points in time, then each envies [Person B's] resources at the end of the year, and the division is therefore not equal. But if we look at envy differently, as a matter of resources over an entire life…then no-one envies [Person B's] bundle, and the distribution cannot be said to be unequal on that account.' (at p. 83) For a useful comparison between Daniels and Dworkin see discussion in Wagland, R. (2012) 'Social Injustice: Distributive Egalitarianism, the Complete Life View and Age Discrimination' in In, Lesser, Harry (ed.) *Justice for Older People* (Rodopi, Amsterdam) 143-160.

should not be seen as creating an inequality between different individuals at a particular point in time (all of whom would have the same access to benefits over a lifetime) but only inequality between our past and future selves. It is this feature of age rationing which, according to Daniels, distinguishes it from rationing on grounds of race or sex. 'It is now possible to explain why the appeal to an age criterion in some rationing schemes works differently from appeals to race or sex criteria. From the perspective of institutions operating over time, the age criterion operates within a life and not between lives…it is rational and prudent that I take from one stage of my life to give to another, in order to make my life as a whole better.'[27]

It is important to recognise, as Daniels himself emphasises, that his prudential lifetime account is not intended to stand as an endorsement of piecemeal uses of age as an access criteria to health or other benefits. It only justifies age based rationing where this fits into a complete prudential scheme and where each instance of the use of age reflects a prudent choice. It would not justify, for example, the imposition of restrictions which deny all health care to those who have reached the age of 70 as this is unlikely to be a limit which a prudent planner would choose. Daniels also makes a number of very important background assumptions. First, his account assumes that resources are limited and must be rationed and that rationing will involve defined trade-offs between individuals such that providing a particular medical treatment to one individual will reduce the resources available to spend on another. Second, Daniels is clear that his account will only result in fair outcomes in a society where other background conditions of justice apply. It does not easily translate to a society (such as, he argued in 1985, the UK) in which these background conditions do not obtain because, in such cases, differential treatment of one age group may serve to entrench existing disadvantage. As, Daniels points out, the worst off among the elderly are very often those who have been worst off at every stage of their lives.

Notwithstanding these caveats, Daniels' account of the complete life view has been subject to criticism, primarily because it appears to ignore the moral importance of helping people who are badly off *today*. An example given by Parfit illustrates this well. If two individuals are in pain, but one in much worse pain than the other, and if we are only able to assist one of them, then while we would wish to help both we will give priority to the one in worst pain. In determining who to assist we are unlikely to consider relevant the degree of pain each has

[27] Daniels, N. ibid., p.96.

experienced in their lives to date, as a complete life view of equality would suggest we should. Even if the individual in only mild pain today has endured much more pain over the course of his life than the individual in terrible pain today, we will not give him priority for this reason. This is because we attach moral significance to helping those who are badly off today (even if they will not have been worse off over a lifetime).[28] The worry is that a complete life view will permit distributions which give rise to extreme inequality between generations at a particular moment in time, or which allow individuals to be very badly off at a particular moment in time. Of course, on Daniels' account, the distribution of age related benefits will be dictated by prudence and this will eliminate many such distributions which leave individuals very badly off at a particular moment. As Mckerlie notes, Daniels account, unlike other versions of the complete life view, is compatible with the view that a particular distribution is unfair at a particular moment in time, even where all will have the same experience over a lifetime, if it is not one that a prudent planner would have chosen.

However, McKerlie argues that even a distributive scheme such as that advocated by Daniels, where the requirements of prudence are intended to constrain what is permitted, may still result in extreme inequality or unacceptable hardship. This is because, according to McKerlie, prudence is likely to dictate that it would be unwise to save many resources for extreme old age for a number of reasons. First, because we are statistically far less likely to face extreme old age so it would be – on Daniels' account – imprudent to reserve significant resources for this eventuality. Second, because, as McKerlie argues, prudence will most likely favour maximising health earlier in our lives because it is then that we are most likely to be fulfilling plans and projects, such as having and raising a family, which have the greatest overall impact on the success of our lives as a whole and indeed on our well-being later in life. Third because, given the frailties that are likely to accompany extreme old age, we may benefit less from the same pot of resources at this stage of life than we would have done from the resources at an earlier stage. For these reasons he concludes that 'prudence would save very little for extreme old age, which is why we should hesitate to use it as the test of justice for the elderly. The problem is not that it permits inequality between the young and the old, but that it might justify the extreme inequality.' We need instead, he argues, some other limits to explain why extreme inequality, harsh treatment and social exclusion are morally unacceptable. For McKerlie the solution lies in the idea of priority – that we are

[28] D Parfit, 'Comments' (1986) 96 *Ethics* 832, at 869–70 discussed in Herring, J. (2009) *Older People in Law and Society* (OUP, Oxford).

morally obliged, at any particular moment in time, to help those who are very badly off, even if we could do more good elsewhere and even if, across a lifetime, the person we choose to help will thereby be better off than others.

A second response to Daniels and to others who subscribe to a complete life view is to say that the argument that age criteria do not produce unequal benefits over a lifetime is not an answer to those who object to age discrimination because the wrong of age discrimination lies elsewhere. This is the approach taken by Cupit.[29] He argues that even those who strongly object to the use of age to determine access to benefits do not object to all examples of synchronic inequality. In other words they see nothing inherently wrong with the idea of taking turns. So, he argues, the source of our intuition that there is something wrong with age discrimination must lie elsewhere. Further, he notes, the fact that we use an irrelevant criterion to ration access to benefits today is also not sufficient to make that practice unfair. He gives the example of a policy which, in times of water scarcity, rations the use of water by permitting those who live in odd numbered houses to use a sprinkler to water their gardens only on odd days of the month, and those who live in even numbered houses only on even days of the month. It is, he notes, difficult to argue that such an arrangement is unfair even though it produces synchronic inequality on the basis of an irrelevant factor (house number). Herring objects to Cupit's argument here, arguing that he overlooks the point that the use of age, unlike the use of house number, carries with it a demeaning, stigmatizing quality. 'A person treated in a disadvantageous way due to their house number will not feel they have been demeaned or stigmatized. Where a person is disadvantaged due to their age in our society, this normally reflects assumptions about them based on their age which are derogatory.'[30] However, I'm not sure that this is what Cupit intended to suggest. His point is simply that if requiring people to take turns by using even an irrelevant characteristic is not always wrong, then we need to look elsewhere to diagnose what is wrong with age discrimination, or with particular instances of it.

As well as suggesting that not all forms of synchronic inequality are unfair, Cupit argues that the fact that a particular distribution of goods is diachronically equal is not sufficient to make it fair, even if it does not harm our individual interests: 'the mere fact that everyone might benefit from a practice involving age discrimination is no reason to believe the practice cannot be unjust.' This is, he argues, because not all injustice is comparative and while the

[29] Cupit, note 20 above.
[30] Herring, J., note 28 above, at p.32.

complete life view may be able to address worries about comparative injustice that may arrive from a particular distribution, it does nothing to allay concerns about other harms which it may create. In this respect the complete life view of equality, it seems, is susceptible to the same problems as are other conceptions of formal equality. It has long been recognised that adherence to formal equality, or consistency of treatment, while crucially important in some contexts, is insufficient to meet the broader aims of anti-discrimination law because it fails to deliver substantive equality. This is both because the use of protected characteristics in determining how individuals and groups are to be treated may create harm, even where there is no inequality of treatment; and because treating individuals equally in some contexts serves to create or entrench existing disadvantage.

Cupit suggests that a source of injustice, which may exist even where there is a diachronically fair distribution of goods, lies in the message which may be communicated by permitting unequal treatment at a moment in time: 'If we want to know whether such practices as denying expensive medical care to the very aged, having a mandatory retirement age, or requiring older citizens to have their driving skills retested are unjust, then, if we are relying on the argument from status, we have to ask not (or not simply) what distribution of benefits (over, or within, a life) such practices will tend to generate, but what, if anything, such practices will *express*.'[31] He suggests that age discrimination will be wrong if the use of age is based on assumptions which are false and derogatory and which therefore incorrectly treat others as inferior. Here Herring and Cupit concur, although Herring goes further than Cupit, suggesting that the use of age may be demeaning not only where it involves derogatory judgement but also where age is irrelevant. Both agree that a demeaning use of age remains demeaning even if the individual concerned enjoyed a relevant advantage at a different stage of their lives.

Intergenerational equality and the fair innings argument

The complete life view of equality suggests that there is nothing wrong with age discrimination today because it does not create inequality over the course of complete lives. We *may* discriminate on grounds of age – use chronological age to organise and ration access to various benefits for example – because no inequality is thereby created. Another, related, argument, known as the fair innings argument, says we *should*, sometimes, discriminate on grounds of age in order to avoid inequality or to achieve substantive equality between the

[31] Cupit, note 20 above, p.710

generations. This is because the older generations have acquired some advantage over the younger, as a result of having lived or worked for longer. If I am older I have already had an advantage which a younger generation have not (yet) had - time alive. Treating old and young equally today may preserve this advantage to the older generation at the expense of the younger and may serve to permanently exclude younger generations from the opportunities enjoyed by those who have gone before them. There are several versions of the fair innings argument[32] but, typically, its advocates argue that where resources (health care spending) are scarce, priority in the distribution of those resources should be given to the younger generations who have not yet had something – a career, a long time alive - over the older generations who have. It is, in essence, an argument for a form of positive discrimination. The substantive inequality it aims to correct is not – as is the case in relation to sex or race discrimination – one rooted largely in historical discrimination against or persecution of a particular group, but one that is necessarily generated by the passage of time.[33] Thus, while the complete life view arguments for restricting access to health care are generally equally applicable to restrictions on health care at any age (justifying lower and upper age limits for screening programmes for example) fair innings arguments apply to restrictions on health care for older patients who have already lived a 'fair innings,' however that is defined, for the benefit of those who have not yet done so.

Callahan advocates a version of the fair innings argument which he terms the biographical life span account.[34] His primary concern in doing so is not to redress perceived inequalities between the health care spend on different generations but is with challenging the presumption that the goal of medicine is to continue to push life expectancy higher with all the resource implications that entails, for no matter what advancements in medical technology produce, we will all die eventually. He argues instead that society needs to reach a new consensus on the ends of age and ageing and to agree a 'natural lifespan' the achievement of which, by all, would then provide a suitable goal for modern medicine. Beyond that natural lifespan, the state would be under no obligation to provide treatment

[32] See Tsuchiya who identifies at least four versions of the fair innings account: The original fair innings account, the extended fair innings account, the relative fair innings account and the biographical account in Tsuchiya, A (2000) 'QALYs and Ageism: Philosophical Theories and Age Weighting' *Health Economics* 9 57-68.

[33] And, in some cases, by changing circumstances which mean the younger generation is unable to access the same opportunities as the older generation once enjoyed – for example barriers to entry to the job market for young people.

[34] Callahan, D. (1987) *Setting Limits* (Simon and Schuster, New York).

aimed at extending life, but would continue to be obliged to provide long term care and medical interventions aimed at reducing pain and suffering.

Williams, on the other hand, provides a revised account of the fair innings argument which is firmly rooted in redistributive equality.[35] The premise of the argument is that health care resources are finite and that increased expenditure in one area inevitably reduces expenditure on another. Against this background Williams argues that it is unfair to consume resources on prolonging the lives of those who have already had a fair innings at the expense of those who have not.

> 'If what we wish to equalize is lifetime experience of health, then it indicates that those who have had a 'fair innings' (like me) should not expect to have as much spent on a health improvement for them as would be spent to generate the same benefit for someone who is unlikely ever to attain what we have already enjoyed. It calls for self-restraint by us elderly and especially by those of us who have flourished in health terms throughout our lives. Otherwise we may find that demands are being made on the health care system which will deny health improvements to the less fortunate. Unfortunately, that restraint will be called for at a time when our current health is declining and when it would be perfectly possible to spend vast resources on us in the vain pursuit of healthy immortality.'[36]

Williams' account is sensitive to the objection that we all have very different experiences of health during our lifetimes and that two individuals who have reached the same age will not necessarily have enjoyed the same health related quality of life. In such circumstances it seems unfair to deny resources to the individual who has had a long but unhealthy life, in favour of the individual who has had a (so far) shorter but healthy life, because the former has had a 'fair innings.' In order to deal with this problem he proposes that the relevant threshold, after which restraint in health spending is required, is not a simple biological age but instead is a number of quality adjusted life years. The goal should be, as far as possible, to equalise the number of quality adjusted life years we are all expected to lead: 'the concept of a 'fair innings' needs to be extended beyond *simple* life expectancy to embrace *quality-adjusted* life expectancy. Otherwise it will not be possible to reflect the view that a lifetime of poor quality health entitles people to special consideration in the current allocation of health care, even if their life expectancy is normal.'[37] Thus an individual who has lived until or beyond the

[35] Williams, A. (1997) 'Intergenerational equity: an exploration of the fair innings argument' *Health Economics* 6 117-132.
[36] Ibid at p. 129
[37] Ibid at p. 121

allocated 'fair innings' but has done so in poor health, will remain entitled to the share of resources needed to get him to his fair share of quality related life expectancy.

Much of the academic debate on age rationing in health care has taken place in the context of considering whether Quality Adjusted Life Years (QALYs) are an appropriate measure of cost effectiveness for use in determining which health interventions should be available. As seen in chapter two, QALYs combine the health related quality of life a patient may expect to have following a particular intervention or treatment, with the number of years of life they are expected to have remaining. Thus they provide a measure of the effectiveness of the intervention. They are therefore primarily a measure of efficiency - how to maximise health gains per pound in the population as a whole, without concern for how those health gains are to be distributed across the population. Because of this disregard for any inequalities it produces, the methodology has been criticised both for resulting in age-discrimination and for not being discriminatory enough. For on the one hand, as explained in chapter two, the QALY will disadvantage those with a lower remaining life expectancy and therefore indirectly discriminates against the elderly. On the other, it values a health gain equally at whatever stage of life it occurs and is thus unable to prioritise resources for those who have had, or who are expected to have, fewer years of healthy life. Rather than being an argument which justifies the indirect discrimination inherent in the QALY methodology, therefore, the fair innings argument (or at least most versions of it) is an argument which is incompatible with it.[38]

The most vocal critic of the discriminatory potential of any QALY methodology has been Harris who argues for an age-indifference principle in the allocation of health care while retaining support for a very limited version of the fair innings argument.[39] His key objection to the use of the QALY is that the methodology, at least potentially, will prefer providing treatment to those who have many life years remaining to enjoy the benefit of the treatment and thus restrict access for those who have not long left to live. This is a mistake, he argues, because

> 'All of us who wish to go on living have something that each of us values equally although for each it is different in character, for some a much richer prize than for others, and we none of us know its true extent. This thing is

[38] See discussion in Tsuchiya, note 32, above. Tsuchiya argues that it is possible to construct versions of the fair innings argument which are compatible with QALY maximisation where QALYs are themselves weighted to take account of age and life expectancy.
[39] Harris, J. (1985) *The Value of Life: An Introduction to Medical Ethics* (Routledge, London)

> of course "the rest of our lives". So long as we do not know the date of our deaths then for each of us the "rest of our lives" is of indefinite duration. Whether we are 17 or 70, in perfect health or suffering from a terminal disease we each have the rest of our lives to lead. So long as we each ... wish to live out the rest of our lives, however long that turns out to be, then if we do not deserve to die, we each suffer the same injustice if our wishes are deliberately frustrated and we are cut off prematurely.'[40]

The debate on whether the use of the QALY in practice to determine availability of treatments available on the NHS produces results which discriminate against the elderly was explored in some detail in chapter two.[41] It will be recalled that those in favour of retaining the QALY methodology tended to advance arguments that, while potentially indirectly discriminatory, the application of the QALY methodology in practice does not disadvantage older patients. They do not choose to argue that any indirect discrimination resulting from the use of the QALY is justified.

Harris, however, has responded forcefully to this approach by noting that the fact that the QALY methodology does not disadvantage elderly in practice is not the end of the story as far as age discrimination is concerned. The argument, he suggests, gives us

> 'no reasons to suppose that suggestion of unjustified discrimination on the grounds of life expectancy does not arise simply because NICE does not, in point of fact, put its money where its mouth is. To suggest that people are a low priority for health resources, are less worth helping, are less worth the concern and respect of the State as expressed through its publicly funded bodies like the NHS and indeed NICE is offensive. It is an attack on their dignity and standing in the community, and therefore prejudicial and unacceptable. That these principles have not, and according to NICE officials, probably will never be, put into practice does not mean that the public espousal of them and the ageist ideas that inform them do not amount to discrimination.'[42]

Notwithstanding his rejection of the QALY because of its ageist credentials and his adherence to an age-indifferent approach to resource allocation, Harris does subscribe to a limited fair innings account. He argues that in – and only in - situations where only one of two patients can be saved and one has lived a 'fair innings' and the other has not, the younger patient should be saved. This is because, although both suffer same injustice of having their remaining life time left cut short, one also suffers the additional injustice of not having had a fair innings. He strongly objects to the use of age in any other way, however.

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[40] Ibid, p.89
[41] At 2.3.1
[42] Harris, J, and Regmi, S. (2012) 'Ageism and Equality' *Journal of Medical Ethics* 38, 263-66.

It will be noted from the above discussion that much of the debate on the merits of the fair innings argument is played out in the context of scenarios which imagine having to save one patient at the expense of another. The debate tends to relate to considering the justice of providing (expensive) treatments which are aimed at extending the life of patients who have already had a (reasonably) long life if the consequences of this may mean less opportunity for younger patients to reach the same age (or indeed less resources available to meet the other health care needs of older patients.)[43] This is because the 'good' at stake in this debate is normally characterised as 'years alive' rather than any other version of health. However, as noted in chapter two, much health care spending on older people and much evidence of age discrimination relates to interventions which are not, or at least not primarily, life extending. Yet there is much less discussion in the literature of the fairness of rationing treatment for older patients which is not intended to extend life but to improve quality of life. It is not suggested anywhere, for example, that fairness demands services such as physiotherapy to enhance mobility be restricted to older patients in order to free funds for improving similar services for younger patients because the younger patients have had, overall, less mobile years. On the contrary, Callaghan, it will be recalled, does advocate the continuance of care and interventions to reduce pain and suffering in his biographical life span, although the extent of this duty is unclear. Harris would clearly reject any reduction in quality of life related health spending for older people. And Fleck, who does advocate age based rationing for certain expensive life extending treatments, notes that while it is sometimes right to ration by age, there will be numerous scenarios in which age indifference is a moral requirement.[44]

Conclusion

The three main anti-ageist arguments discussed above - those of McKerlie, Cupit and Harris – all assert that diachronic equality is not sufficient to prevent the use of age in rationing from amounting to harmful discrimination. As Wagland points out, each of the arguments appeals to the idea that individuals also have important and morally significant synchronic interests and that policies which violate these synchronic interests may prove unjust even where they preserve equality between individuals over a lifetime. McKerlie appeals to the idea of the moral imperative of helping those who are very badly off today even if, over a complete lifetime, they will have been better off than others. The synchronic interest is to have a

[43] A point made by Fleck in Fleck, L. (2010) 'Just Caring: In Defence of Limited Age-Based Healthcare Rationing' *Cambridge Quarterly of Healthcare Ethics* 19, 27-37.
[44] Ibid.

minimally decent quality of life at each moment in time, no matter how well off we have been in the past or will be in the future. For Cupit and Harris the relevant synchronic interests include the harmful message that may be conveyed by age based rationing. Both appeal to the idea that actions can convey that those they concern are less valued than others even where no distributive inequality is thereby created. Thus, according to Cupit, age based rationing may still cause harm even where no diachronic inequality is created because at least some uses of age to ration goods will involve a false derogatory judgment. Harris argues that a prima facie ageist approach may still be harmful even where it is used in a way which creates no disadvantage, precisely because it implies that some individuals are less worthy of concern on account of their age.

Each of these accounts of relevant synchronic interests bears a very strong resemblance to human dignity, or at least to some common definitions of human dignity, as will become apparent in the subsequent chapters of this thesis. Indeed Harris invokes dignity explicitly in his argument above, although he does not himself go on to develop or define the concept. If dignity is indeed a candidate for a synchronic interest which is capable of rendering (at least some) uses of age based rationing wrong – even when there is no distributive inequality across the lifecourse - then it is vital to understand what dignity requires. The next three chapters of this thesis explore the various meanings of dignity, including those which Cupit, McKerlie and Harris invoke here, in order better to understand whether and when protection of dignity is likely to be incompatible with the use of age to determine access to benefits.

CHAPTER FIVE: AN INTRODUCTION TO DIGNITY

Introduction

The following chapters aim to identify the different meanings of dignity as they apply in two contexts of particular relevance to the questions identified in preceding chapters. These are health care law (including state provision/allocation of health care resources) and equality law. The purpose of doing so is to assess how different meanings of dignity may bear on questions about the appropriate use of age based distinctions in relation to health care, and in particular the allocation of health care resources. Theoretical and empirical approaches to defining dignity will be considered but the primary focus will be on identifying legal meanings – actual or potential – which are capable of assisting courts in determining when age discrimination may be justified.[1]

It was made clear in the introductory chapter that dignity is at the same time a popular candidate for a – or the – theoretical foundation for anti-discrimination law and a multi-faceted concept whose meaning is difficult to identify and apply. There are many who doubt that dignity has any substantive content at all, or certainly any which is capable of rendering it capable of useful work as a legal principle, either because it is 'vacuous' or because it only ever serves to stand in for another, better defined, concept.[2] While the following discussion will engage with a number of these arguments, its primary purpose is not to defend dignity – or any particular conception of it - against its critics but rather to identify the variety of meanings which dignity may hold and to explore the implications of these different meanings for the problems of justifying age discrimination.

Identifying the meaning(s) of dignity is not an easy task, however. Advocate General Stix-Hackl noted in *Omega* that 'there is hardly any legal principle more difficult to fathom in law than that of human dignity'[3] and Charles Foster notes that 'by and large, with some

[1] McCrudden notes that there is little evidence that philosophical/theoretical meanings have influenced legal – particularly juridical – approaches to the concept of dignity. McCrudden, C. (2008) 'Human Dignity and Judicial Interpretation of Human Rights' *European Journal of International Law* 19(4), 655-724.

[2] See, for example, Bagaric, M. and Allan, J. 'The vacuous concept of dignity' (2006) 5(2) *Journal of Human Rights* 257-270; Macklin, R. (2003) 'Dignity is a useless concept' *British Medical Journal* 327: 1419; Schopenhauer, A. *The Basis of Morality* (trans. and intro. by A.B. Bullock, 2005), Pt II, Critique of Kant's Basis of Ethics discussed in McCrudden (2008) note 1 above.

[3] *Omega Spielhallen- und Automatenaufstellungs-GmbH v Oberbürgermeisterin der Bundesstadt Bonn* (C-36/02) [2004] ECR I-9609, Opinion of Advocate General Stix-Hackl delivered on 18 March 2004 at para. 74

honourable exceptions, the courts have not tried to fathom it, being content instead to assume that it is a good thing, that their audience have a fair idea what it means, and that it needs to be protected.'[4] As will become clear in the following discussion, there is a lack of consistency in the use, meaning and implications ascribed to dignity by courts and legislatures both in different jurisdictions and within the same jurisdiction.[5] Dupre notes that while dignity has a more established meaning in some jurisdictions, it 'remains a concept which does not fit easily into the existing theoretical categories of law and which has no definition at the European level'[6] Buijsen is even more bleak in his assessment of the possibility of pinning dignity down, arguing that 'in general, the only accurate description of the meaning of human dignity consists of the entire body of human rights (universal, indivisible, interdependent, and interconnected, according to human rights doctrine) insofar as it is part of the legal system.'[7] For Carozza, however, the 'fact of disagreement as to the meaning of dignity does not constitute a reason for discarding the concept, but instead for engaging in continued discussion to determine its meaning.'[8]

The following chapters cannot attempt to categorise *all* legal encounters with dignity. Such a task is made impractical not only because explicit references to dignity now appear in such a vast array of legislative instruments and a growing body of jurisprudence but also because a full account of dignity would also need to identify instances where the concept of dignity may be at work even if not labelled or even recognised as dignity by the courts or other institutions. As will be seen, dignity is closely associated with a number of other concepts - and indeed, arguably, has a number of synonyms – such as (but not limited to) respect and integrity. Sometimes the law engages with what we might recognise as dignity, or important elements of it, without articulating the concept in this way. Thus in *Omega* AG Stix-Hackl

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Nonetheless she went on to attempt to define it, arguing that ''Human dignity' is an expression of the respect and value to be attributed to each human being on account of his or her humanity.' (at para. 75)

[4] Foster, C. (2011) *Human Dignity in Bioethics and Law* (Hart, Oxford) p. 85

[5] McCrudden (2008) note 1, above. Advocate General Stick-Hakl acknowledged this point in *Omega* where she explains that the guarantee of dignity recognised under Community law is different from the guarantee of dignity under German Basic Law – the latter amounting to an independent right, the former to a principle of interpretation. See further discussion of this point below.

[6] Dupre, C. (2009) 'Unlocking human dignity: towards a theory for the 21st century' *European Human Rights Law Review* 2, 190-205 at para. 192.

[7] Buijsen, M. (2010) 'Autonomy, Dignity and the Right to Health Care: A Dutch Perspective.' *Cambridge Quarterly of Health Care Ethics* 19, 321-328.

[8] Carozza, P. (2008) 'Human dignity and judicial interpretation of human rights: a reply' *European Journal of International Law* 19(4) 931-44.

pointed out that the 'idea of dignity of man also finds expression in other concepts and principles that have to be safeguarded such as personality and identity.'[9]

Instead, this chapter introduces dignity as a legal concept and identifies some of the key distinctions in the different meanings given to dignity and in the uses to which dignity is put. The discussion is organised around three – closely related – sets of distinctions. The first section examines the various roles dignity may play in legal analysis, whether as a value, a principle or a right; the second section looks at the question of who has dignity and where dignity comes from; and the third section considers some of the main candidates for a substantive meaning for dignity. The next two chapters will then explore in more depth the legal uses of dignity in contexts of particular relevance to the central questions of the justification of age discrimination identified in the earlier chapters. These are health care (including the allocation of health care resources) (chapter six) and equality (chapter seven). Finally chapter eight assesses the significance of these different meanings for the question of whether and when age discrimination in health care may be justified.

The function of dignity

A first question concerns the status or function of dignity (whatever its substantive meaning) in relation to human rights. As is well known, dignity makes an appearance in most international human rights texts and in a number of domestic constitutional documents.[10] A closer look at these instruments (and of the interpretation of them by the courts) reveals that dignity performs a range of different – though related - functions across these various instruments and sometimes performs more than one function within the same legal instrument.

First dignity may serve as a constitutional value which provides a theoretical basis for substantive rights. Thus, for example, dignity famously appears as a foundational value in the UDHR, Article 1 of which provides 'All human beings are born free and equal in dignity and

[9] Note 3, above, at.79. For further discussion of this point see Feldman, D. (1999) 'Human dignity as a legal value: Part 1' *Public Law*, Win, 682-702.

[10] Including, for example: Universal Declaration of Human Rights 1948 ('UDHR'); International Covenant on Economic, Social and Cultural Rights 1966; International Covenant on Civil and Political Rights 1966; EU Charter of Fundamental Rights 2000; German Basic Law 1949; The Constitution of the Republic of South Africa 1996 ('South African Constitution'); Constitution of the Republic of Hungary 1949; Israel, Basic Law: Human Dignity and Liberty 1992.

rights.'[11] Likewise the International Covenants on Civil and Political Rights, and on Social and Economic Rights, both state in their Preambles that 'these rights derive from the inherent dignity of the human person.' In this context dignity is intended to explain why it is we have rights. This foundational use of dignity – famously so in the case of the UDHR – does not appear to depend on any particular substantive conception or meaning of dignity. McCrudden notes that dignity was engaged to provide this theoretical foundation in the absence of consensus. 'Its utility was to enable those participating in the debate to insert their own theory. Everyone could agree that human dignity was central, but not why or how.'[12] Of course where deployed to identify or interpret particular rights, some concept of what dignity involves – and indeed where it may stand in relation to other constitutional values – is required.[13]

Second, or additionally and in consequence of its role as a foundational value, dignity may serve as a principle which, alone or alongside other principles, is deployed to assist in the interpretation and application of substantive rights, including in the determination of whether they should be extended. Thus, for example, the South African Constitution explicitly requires that the substantive human rights provisions be interpreted in accordance with the values of dignity, equality and freedom.[14] Likewise, the CJEU has confirmed that dignity is a general principle of EU law. In *Omega*, the Court was required to determine whether a restriction on a service provider's ability to offer a killing game (restricted by German courts as incompatible with dignity under the German Basic Law) was compatible with community law. Advocate General Stix-Hackl had argued that 'Human Dignity…forms the underlying basis and starting point for all human rights distinguishable from it; at the same time it is the point of convergence of individual human rights in the light of which they are to be understood and interpreted.'[15] The Court of Justice agreed holding that 'the Community legal order undeniably strives to ensure respect for human dignity as a general principle of law.' [16] The objective of protecting human dignity was therefore compatible with EU law and the Court found that, on the facts, Germany's restriction had gone no further than necessary to achieve the objective and was therefore justified.

[11] See also South African Constitution, Article 1, which states that human dignity is one of the values on which the state is founded.
[12] Note 1, above, p. 678.
[13] A point discussed in Feldman, D. (2000) 'Human dignity as a legal value: Part 2' *Public Law*, Spr. 61-76.
[14] At S39.
[15] Opinion of Advocate General Stix-Hackl, note 3, above, at 76.
[16] Note 3, above, at 34 of the judgment.

Third, a number of constitutional documents include self-standing rights to human dignity or to certain conditions deemed necessary for dignity. The South African constitution, as well as identifying dignity as a foundational value and interpretative principle, provides at Article 10 'Everyone has inherent dignity and there is a right to have dignity respected and protected.'[17] Likewise the European Charter of Fundamental Rights, as well as giving Dignity a foundational role in its Preamble,[18] and in naming Title I 'Dignity' (and therefore suggesting a particularly important foundational role for dignity in relation to the Title I rights) includes three specific rights to dignity (only the first of which falls within Title 1): Article 1 provides that 'Human Dignity is inviolable. It must be respected and protected; Article 25 includes a right for the elderly to live a life of 'dignity and independence'; and Article 31 gives rights to workers to working conditions which respect 'health, safety and dignity.'

There is no inherent conflict in dignity taking on more than one role at the same time and in the same instrument. As Waldron notes, '[i]t is perfectly possible that human dignity could be the overall telos of rights in general, but also that certain particular rights could be oriented specifically to the explicit pursuit of that objective or to protecting it against some standard threats to dignity, while others were related to this goal in a more indirect sort of way.' [19] Certainly the Court of Justice was untroubled by the implications of a plurality of functions in *Omega*, noting that while dignity serves two different functions in the German Basic Law (as a general principle and as a separate fundamental right) it would serve only one in Community law (as a principle of interpretation): 'There can be no doubt that the objective of protecting human dignity is compatible with Community law, it being immaterial in that respect that, in Germany, the principle of respect for human dignity as a particular status and an independent fundamental right.'[20] On the other hand, a lack of clarity about the role of dignity may inevitably lead to confusion both about its substantive meaning and to the coherence of any legal analysis involving dignity. As Moon and Allen note, the 'chameleon-like quality of dignity has meant that reference to it has often been made without any express

[17] See discussion of dignity in South African constitutional law in Campbell, J. (2011) 'Litigating human dignity: the Roman-Dutch common law' *European Human Rights Law Review* 4, 375-8.
[18] 'Conscious of its spiritual and moral heritage, the Union is founded on the indivisible, universal values of human dignity, freedom, equality and solidarity.'
[19] Waldron, J. (2009) 'Dignity, Rank and Rights' *The Tanner Lectures on Human Values* delivered at University of California, Berkley, April 21-23 2009; see also Kidd White, E. (2012) 'There is no such thing as a right to dignity: A reply to Conor O'Mahoney' *International Journal of Constitutional Law* 10(2) 575.
[20] Note 3, above, at 34. There was no reference made to the apparent plurality of functions of dignity in the European Charter of Fundamental Rights

consideration of which express role it is to play and which is the most apt, and importantly, how therefore the concept works.'[21]

In addition, the use of dignity to perform a particular function may be contested. It is the use of dignity as a right which is perhaps most controversial.[22] For Feldman, this is because dignity is something which it may simply be impossible to guarantee: 'the notion that dignity can itself be a fundamental right is superficially appealing but ultimately unconvincing. We are conceived and born, and most of us live and die, in circumstances of significant indignity. It seems (at least to someone of my pessimistic cast of mind) that human dignity is a desirable state, an aspiration, which some people manage to achieve some of the time rather than a right. Nevertheless, human rights, when adequately protected, can improve the chances of realising the aspiration.'[23] For Moon and Allen the difficulty with recognition of a right to dignity is rather with the impact this has on the evolution of dignity as a legal concept. Their concern is that treatment of dignity as a right will inevitably lead to legal rigidity and the 'ossification' of the concept; use of dignity as a value or principle on the other hand permits flexibility so as to 'enhance the process of reasoning and the principle will set a boundary to the discourse which must be obeyed or negotiated.' [24]

Some commentators have suggested alternative roles for dignity. McCrudden, argues that, notwithstanding a lack of consensus on the substantive meaning of dignity, it nonetheless serves a purpose as providing a 'common metric' where courts or others are required to grapple with otherwise incommensurable values. This is particularly the case where courts are tasked with performing a proportionality analysis in which they may be called on to weigh a range of different and often conflicting values and interests in the balance.[25] In this context dignity provides 'a language in which courts can indicate the weighting given to particular rights and other values...[w]hen a particular right or other value is described as

[21] Moon, G, and Allen, R. (2006) 'Dignity discourse in discrimination law: a better route to equality?' *European Human Rights Law Review* 6, 610-649 at 615.
[22] See, for example, discussion in Feldman, D (1999) 'Human dignity as a legal value: Part 1' *Public Law, Win,* 682-702; O'Mahoney, C. (2012) 'There is no such thing as a right to dignity' and 'There is no such thing as a right to dignity: a rejoinder to Emily Kidd White' *International Journal of Constitutional Law* 10(2), 551 and 585 and rejoinder by Emily Kidd White, note 19, above.
[23] Feldman, ibid at p. 682.
[24] Moon and Allen, note 21, above at 615.
[25] At least where a 'balancing' approach to the proportionality test is taken. See discussion of the different variants of the proportionality test in chapter one.

engaging dignity, this indicates that the court considers that considerable (in some cases even overwhelming) weight should be attributed to it.'[26]

There seem to be two distinct ways in which dignity may feature in such an analysis. First, where dignity is strongly associated with a particular right or value – as noted in the quote from McCrudden above – it may tip the scales in favour of protecting that right, or at least of strict scrutiny of any restriction on that right by the Court. The second is where dignity appears on both sides of the scales and where the Court must investigate which solution – to use McCrudden's phrase - best 'comports with dignity.'[27] Thus, by way of illustration, McCrudden discusses two decisions of the German Constitutional Court relating to abortion, each of which took a different approach to the dignity interests at stake. In the *First Abortion Decision*[28] the duty of the state to protect life was associated with human dignity whereas the constitutional rights of the mother to develop her personality were not. As a result, as McCrudden notes, 'once dignity entered the balancing calculus on the side of the life interest, the conclusion that the protection of the foetus's life must receive priority over the women's freedom was inevitable.'[29] In the *Second Abortion Decision,*[30] however, nearly twenty years later, dignity was associated with both sets of rights and thus provided a common metric by which to engage in a more even handed balancing of the rights at stake. Of course either approach necessitates understanding of substantive meaning of dignity both to identify which rights and interests are associated with dignity and to assess the relative weight of the various dignity interests at stake where these appear on both sides of the equation.[31]

The source of dignity

A second distinction important to the legal use of dignity concerns its source and, therefore, the question of who has or is entitled to dignity, whatever that entails. It also has important bearing on its meaning.[32] There are two broad claims. The first is that dignity is inherent

[26] At p.716. See also Feldman who argues that dignity is perhaps best understood in terms of a language for expressing moral problems rather than as a value for resolving them.
[27] McCrudden, note 1 above, at p.79.
[28] 39 BverfGE R 1 (1975).
[29] Ibid, p.716
[30] BverGE 88, 208 (1993).
[31] See also Charles Foster who advocates a dignity maximising analysis for bioethical problems: 'One should ask of every proposed solution to every problem in bioethics or medical ethics (every 'transaction'): 'Is this the solution that maximises the amount of dignity in the world?'' Foster, C (2011) note 4, above. Feldman, by contrast, believes dignity is a way of expressing moral problems, rather than a mechanism for resolving them. Feldman (1999) note 22, above.
[32] McConnachie argues that there are two, separate but related claims: first that we are of equal moral worth; and second that we therefore deserve to be treated with equal respect. The source of our moral worth will dictate

(either because of something special about human beings – such as the capacity for rational thought or moral reasoning - or because it is something given to us by God). Among proponents of secular conceptions of inherent dignity, the most well-known by far is Kant. While there is not scope or need to do justice to Kant here, it should suffice to say that most interpreters of Kant's view on dignity concur that, for Kant, dignity is an inherent value which attaches to humanity (and only humanity) by virtue of the fact that only humans have the capacity to be moral: 'But a human being regarded as a person, that is, as the subject of a morally practical reason, is exalted above any price; for as a person he is not to be valued merely as a means to the ends of others or even to his own ends, but as an end in himself, that is, he possesses a dignity (an absolute inner worth) by which he exacts respect for himself from all other rational beings in the world. He can measure himself with every other being of this kind and value himself on a footing of equality with them.'[33]

The second claim is that dignity is not inherent but is something that we can acquire or earn or be given and that can therefore also be taken from us. Waldron, for example, rejects the notion of dignity as intrinsic and absolute worth, normally ascribed to Kant, and is scathing about its influence on the development of dignity as a legal concept, arguing that 'taken on its own, it has had a deplorable influence on philosophical discussions of dignity and it has led many lawyers, many of whom are slovenly anyway in these matters, lazily to assume that "dignity" in the law must convey this specific Kantian resonance.'[34] Waldron argues that, rather, dignity refers to the idea of the assignment of high rank – as traditionally used to indicate someone of high social status – equally to everyone.

Because the origins of dignity have a bearing on the question of who has dignity related rights, this is an issue that exercises bioethicists in particular, raising as it does difficult questions about the dignity and rights of the unborn or those who no longer (or never did) have capacity for rational thought or moral reasoning.[35] It also has implications for the substantive meaning of dignity. It will be seen later in the discussion, for example, that dignity is strongly associated with autonomy in many contexts and this conception is inevitably tied to the question of its source. If, for example, those who lack autonomy

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what is required to respect that worth. McConnachie, C. (2014) 'Human Dignity, 'Unfair Discrimination' and Guidance' *Oxford Journal of Legal Studies* 34(3) 609-629.

[33] Kant, I., *The Metaphysics of Morals (translated and edited by Mary Gregor)* (1996) (CUP Cambridge) at 6:436.

[34] Waldron, note 19 above.

[35] McCrudden, note 1 above, notes that in some jurisdictions, including Israel and Germany, dignity may also protect the rights of the dead.

nonetheless have dignity rights, then it seems dignity must consist of something more than the exercise of autonomy.[36]

The issue also has an important bearing on the question of the status of dignity. If our dignity is something that is not inherent but is rather something that is contingent, on, for example, our treatment by others, or certain other external conditions such as access to food or shelter or healthcare, then it is more difficult to see how it may serve as a foundational value. If society is to decide the conditions under which an individual may or may not possess dignity then it is difficult to see how dignity has any special status distinct from other rights.[37] On the other hand, those who argue that dignity is inherent may find talk of rights to dignity more problematic, given that it is difficult to conceive of having a right to something one already possesses and cannot lose. Of course the existence of inherent dignity may still entail rights to be treated in accordance with that dignity and/or to have it respected.[38]

Others, rather than opting for one source of dignity over the other, have argued that we may have both inherent dignity and dignity which is attributed to – or arises in consequence of - particular behaviour. These are separate conceptions with different implications. Gewirth, for example, one of the most prominent modern dignity theorists, suggested that '[t]he sense of 'dignity' in which all humans are said to have equal dignity is not the same as that in which it may be said of some person that he lacks dignity or that he behaves without dignity, where what is meant is that he is lacking in or is decorum, is too raucous or obsequious not 'dignified'. This kind of dignity is one that humans may concurrently exhibit, lack, or lose, whereas the dignity in which all humans are said to be equal is a characteristic that belongs permanently and inherently to every human as such.'[39] Dignity may therefore serve as a label for different things and it is essential to be clear which sense of dignity is being invoked at any particular time.

A second important set of distinctions related to the source and 'ownership' of dignity is made by Feldman[40], who argues that dignity can operate on three levels: the dignity of the

[36] See Foster (2011), note 4 above, for discussion of this point. He argues that dignity cannot be synonymous with autonomy precisely because those without autonomy still have dignity interests.
[37] See Schroeder, D. (2010) 'Dignity: One, Two, Three, Four, Five, Still Counting' *Cambridge Quarterly of Healthcare Ethics* 19, 118-125, for further discussion of this point.
[38] Waldron, note 19, above; see however Killmister, S. (2010) 'Dignity: Not Such a Useless Concept' 36 *J Med Ethics* 160-164, who argues that this approach renders the concept of dignity so 'thin' that it ceases to be terribly useful, at least in a medical ethics context.
[39] Gewirth, A. (1982) *Human Rights* (University of Chicago Press, Chicago) at p. 27–8.
[40] Feldman (1999) note 22, above.

species, the dignity of the individual and the dignity of groups. The dignity of the species derives from whatever it is that is special or unique about the human species and requires that the special status and integrity of the human species be protected. Legal concern with this type of dignity may manifest itself most obviously in regulation aimed at preventing certain forms of genetic manipulation. The dignity of the group, argues Feldman, is traditionally associated with the recognition of particular groups in society and may require rules which prevent discrimination and recognise and accommodate difference, permitting certain group norms or traditions to be respected and protected. Finally the dignity of the individual is commonly, though not exclusively, linked with autonomy and consent and with respect (whether self-respect or respect from others) and freedom from humiliation and is associated with a broad range of rights and regulation including those protecting reputation, freedom from harassment and requiring consent. While, again, there seems no reason why one should always be forced to choose between these particular conceptions – it is possible for all three forms of dignity to co-exist as they clearly do in law - it is important to note that they may sometimes clash. Thus the dignity of the species may mean that it is incompatible with dignity to allow, for example, genetic manipulation or assisted suicide even where this involves overriding the autonomy and consent of the individuals involved; and the dignity of a group may permit or require positive action which, arguably, may infringe individual dignity, or at least some conceptions of it.[41] As ever, much depends on the substantive meaning attributed to dignity in each case.

The meaning of dignity

These questions about the status and origin of dignity will inevitably inform (and be informed by) attempts to determine the substantive meaning of dignity. It is the substantive meaning which will tell us what dignity requires of us in the way we behave or in the way we treat others. As will become apparent from the following discussion, dignity has many meanings (or, as some would argue, none at all.)[42] What follows attempts to sketch some of the key distinctions – and most important categories – in relation to candidates for substantive meaning. It does not and cannot aim to provide a full account. The following two chapters then offer a more detailed look at the meanings of dignity evident in relation to the legal regulation of health care and of discrimination.

[41] See discussion of dignity and positive discrimination in chapter seven.
[42] Macklin, note 2, above.

Noting the diverse meanings ascribed to dignity in human rights jurisprudence both across and within jurisdictions, McCrudden asks if it is possible to identify a core meaning, common to all of its diverse uses.[43] His answer is that it is, but that the core meaning does not get us very far because of the lack of political and theoretical consensus on what the core meaning then entails. The core meaning he identifies is as follows:

(i) Every human being possesses intrinsic worth by virtue of being human
(ii) This intrinsic worth should be recognised and respected by others. Some forms of treatment by others are inconsistent with or required by this intrinsic worth.
(iii) A claim that the state should be said to exist for the individual human being and not vice versa.

Brownsword and Beyleveld similarly attempt to construct a basic scheme into which the various claims to dignity as a foundational value, identified from a review of legal and theoretical accounts, appear to fit. What these claims have in common, it is argued, is the assertion that each human being has a right to be treated as having inherent value and being worthy of respect.[44] Brownsword and Beyleveld then identify three particular rights which this common foundational idea entails: '[t]his right (to be treated as one who has worth) may then be cashed more specifically as: (a) a right to be respected as one who belongs to the class of human beings, that is, as one who has the distinctive capacities of being human; (b) a (negative) right against unwilled interventions by others that are damaging to the circumstances or conditions that are essential if one is to flourish as a human; and (c) a (positive) right to support and assistance to secure circumstances or conditions that are essential if one is to flourish as a human.'[45]

Individualistic vs Communitarian approaches

One of the most important contrasts in the ways in which these basic framework accounts are then fleshed out both by academic commentators and by the courts is between individualistic (normally autonomy related) accounts on the one hand and communitarian accounts on the

[43] McCrudden, note 1, above. McCrudden notes that when talking about dignity judges seem to be more ready than usual to draw on the jurisprudence of other jurisdictions. This of course raises the issue of whether there is or can be a universal conception of dignity or just different culturally relative ones. See also discussion in Carozza, note 8, above.
[44] Beyleveld, D, and Brownsword, R, (2001) *Human Dignity in Bioethics and Biolaw* (OUP, Oxford).
[45] Ibid p. 6-7.

other.[46] These different approaches have important bearing on answers to the question of who decides what treatment or behaviour is consistent or inconsistent with dignity – or to use the language of Beyleveld and Brownsword who decides what conditions are necessary 'if one is to flourish as a human' (the individual or the community?); and to the related question of when (if ever) dignity rights of individuals may be limited in the interests of others or of the wider community. McCrudden notes that different approaches to these questions are evident in different jurisdictions.[47]

One of the key candidates for a substantive meaning of dignity is that dignity requires allowing or facilitating the individual to pursue their own conception of the good life. As Raz puts it, 'respecting human dignity entails treating humans as persons capable of planning and plotting their future. Thus, respecting people's dignity includes respecting their autonomy, their right to control their future.'[48] Undue interference or failure to support such pursuits is an affront to dignity – within McCrudden's framework it fails to respect intrinsic worth - because this account of dignity requires others to respect individuality and agency. This includes respecting the views of the individual as to what constitutes a life worth living and – as far as possible and consistent with the rights of others – allowing them to pursue it. Rao notes that this is the dominant approach to dignity in the law in the US.[49] Unsurprisingly, such autonomy based and individualistic accounts of dignity tends to be associated with accounts which locate intrinsic dignity in the capacity for autonomy, for if dignity exists by virtue of our capacity for autonomous action then respecting dignity requires the fulfilment of this capacity to be facilitated or at least not inhibited. Accounts of dignity falling into this category tend, then, to have very close links with autonomy and with the idea of the development of individual personality or realisation of identity.[50] Certainly dignity as requiring respect for individual autonomy is normally the version of dignity argued to result from Kant's account of the source of intrinsic human worth, although the attribution of this

[46] See also Rao, N. who distinguishes between 'intrinsic' dignity and 'substantive' dignity in (2011) 'Three concepts of dignity in constitutional law' 86 *Notre Dame Law Review* 183.
[47] McCrudden, note 1, above, notes that these two different approaches can be discerned in the approaches of the legislature and courts in different jurisdictions. Thus, he argues, in the US and in Canada, the approach has been predominantly individualistic whereas the German Constitutional Court has tended to adopt a more communitarian approach and the South African courts have moved between the two. See also Rao who observes that 'The inclination in Germany, France or South Africa is to separate dignity from autonomy in order to expand the legal conception of dignity and give it a more positive, community-based meaning.' Note 46, above, at p.220.
[48] Raz, J. (1979) *The Authority of Law* (Clarendon, Oxford) at p.221.
[49] Rao, note 46, above.
[50] Dupre, C. (2009) note 6, above.

view to Kant is not uncontested.[51] The difficulties in articulating clearly the distinction and the relationship between autonomy and dignity has led some critics to argue that appeals to dignity, or at least to this conception of it, add little to our understanding of human rights.[52]

An alternative view is one in which community has a role in deciding what individual behaviour or treatment by others best comports with dignity or what goods or services are necessary in order to be able to live a dignified life. Communitarian accounts may recognise the importance of allowing individuals freedom to pursue their own goals but differ in the way in which community values may be used to limit this freedom. This approach is well illustrated by German Constitutional Court in the *Lifetime Imprisonment Case* where it held that

> '[t]he constitutional principles of the Basic Law embrace the respect and protection of human dignity. The free person and his dignity are the highest values of the constitutional order. The state in all of its forms is obliged to respect and defend it. This is based on the conception of man as a spiritual-moral being endowed with the freedom to determine and develop himself. This freedom within the meaning of the Basic Law is not that of an isolated and self regarding individual but rather of a person related to and bound by the community. In the light of this community-boundedness it cannot be "in principle unlimited". The individual must allow those limits on his freedom of action that the legislature deems necessary in the interest of the community's social life; yet the autonomy of the individual has to be protected.'[53]

Dupre has argued that this represents a very different vision of dignity from that imagined by the Hungarian Constitutional Court, despite the strong influence of the German Basic Law on the development of the Hungarian constitution. Instead, she argues, in Hungary the conception of dignity is focused on individuality and autonomy where the individual is viewed as someone to be 'considered in isolation and fighting against the state to protect her rights.'[54]

Both individual and (more often) communitarian dignity are associated with entitlement to social and economic rights.[55] In the case of individual dignity there may be recognition that a certain minimum entitlement to essential goods is necessary for the exercise of autonomy. On a communitarian model the concept of what a dignified existence looks like may similarly

[51] See, for example, discussion in Waldron, note 19, above; and in McCrudden, note 1, above.
[52] Macklin, note 2, above.
[53] [1977] 45 BVerfGE 187 discussed in McCrudden, note 1, above.
[54] Dupre, C. (2003) *Importing the Law in Post-Communist Transitions: The Hungarian Constitutional Court and the Right to Human Dignity* (Hart, Oxford) at p. 122.
[55] Kymlicka, W. (2002) *Contemporary Political Philosophy (2nd Edition)* (OUP, Oxford)

require everyone to have access to certain minimum entitlements. The UDHR links dignity with the provision of social and economic rights in Article 22 which provides that 'Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.' Likewise, the Constitutional Court of South Africa held in *Grootboom* that 'A society must seek to ensure that the basic necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality…there can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter.'[56]

Judicial consideration of dignity (at least explicitly) in relation to positive obligations on states to secure minimum welfare provision has not been prominent in the UK Courts, nor indeed in the ECtHR.[57] Of course judicial interpretation of dignity to ground significant positive rights to social and economic entitlements, with the consequent implications for resource allocation, also raises constitutional questions as to the appropriate role of the Courts. It is for the reason that Gearty has welcomed the UK courts' non-engagement with the concept in a number of cases, arguing that a decision to characterise dignity in this way (or indeed in any particular way) is a decision for the political institutions and not for the courts.[58] The role of dignity in relation to the provision of health care as a minimum basic good is discussed in further detail in the next chapter.

Dignity as empowerment vs dignity as constraint

If community values are to help to define the conditions under which the requirements of human dignity are satisfied then it seems inevitable that dignity will sometimes require constraint on individual freedom. Thus the requirements of individualistic, freedom based accounts of dignity as autonomy and communitarian approaches may often conflict. Two major approaches to dignity - 'dignity as empowerment' and 'dignity as constraint' – are identified as the key distinction in legal uses of dignity by Beyleveld and Brownsword who

[56] *Government of the Republic of South Africa and Others v Grootboom and Others* (CCT11/00) [2000] ZACC 19 at 23.
[57] Though Feldman does suggest that dignity was implicated as an underlying constitutional value in, for example, *R v Secretary of State for Social Security, ex parte Joint Council for the Welfare of Immigrants* [1996] 4 All E.R. 385 CA, where respect for 'humanity' was held to prevent withdrawal of benefits from those seeking asylum. In Feldman, D. (2000) 'Human dignity as a legal value: Part 2' *Public Law,* Spr, 61-76.
[58] Gearty, C. (2013) 'Socio-Economic Rights, Basic Needs and Human Dignity: A Perspective from Law's Front Line' in McCrudden, C. (ed) (2013) *Understanding Human Dignity* (Oxford, OUP)

argue that the greatest tension in the uses of dignity is between those who argue that human dignity requires that an individual exercise autonomy and control over their lives, and those that argue dignity requires collective control over autonomy.[59] This tension explains why dignity often appears on both sides of legal dispute and why, as Feldman puts it, 'once it becomes a tool in the hands of lawmakers and judges, the concept of human dignity is a two-edged sword.'[60] Dworkin notes the significance of these two approaches to the question of regulation of hate speech in different jurisdictions which, he argues, represent a 'good faith' difference in the approach to the meaning of dignity: 'in America, but not in Europe, the reigning opinion holds that respecting people's personal responsibility for their own values means allowing them to challenge even the most fundamental assumptions of democratic society, including the assumption that people's lives are of equal intrinsic value and importance.'[61]

There are (at least) two ways in which 'dignity as constraint' may manifest. First, where personal freedom is restricted because of what the 'community' perceives to be necessary to preserve and respect the dignity of the individual in question. Second, where restrictions on autonomy are said to be required in order to respect the dignity of members of the wider community, or for humanity itself. Sometimes both are evident. A much cited and useful example of a case where both dignity as empowerment and dignity as constraint are evident in the arguments of the parties is *Wackenheim v France* where a ban on 'dwarf throwing' was upheld by the Conseil d'Etat on the grounds that this was an affront to human dignity.[62] Mr Wackenheim, who was a dwarf and who wished to participate in dwarf throwing and to earn a living this way, appealed under the international Covenant on Civil and Political Rights, arguing, among other things, the restriction on his freedom to choose to earn his living this was an affront to his dignity and that his job did not constitute an affront to dignity 'since dignity consists in having a job.'[63] The Human Rights Committee reached the same conclusion as the Conseil D'Etat, noting that the ban was 'not abusive but was necessary in order to protect public order including, inter alia, considerations of human dignity which are compatible with the aims of the Covenant.'[64] They did not, however, explain what they meant by dignity, nor whether it was the dignity of humanity as a whole or of Mr

[59] Note 44, above.
[60] Feldman (1999), note 9, above, at 685.
[61] In (2006) *Is Democracy Possible Here?* (Princeton University Press, Princeton) p.33.
[62] Conseil d'Etat, 27 Oct. 1995, req. Nos 136-720 (Commune de Morsang-sur-Orge), and 143-578 (Ville d'Aix-en-Provence).
[63] *Wackenheim v. France*, CCPR/C/75/D/854/1999: France, 26 July 2002 at para. 3
[64] ibid at para. 7.4

Wackenheim and other dwarves in particular – or both - which was at stake. Similarly, and another good example of how a community defined conception may conflict with individual dignity, is the US Supreme Court case of *Indiana v Edwards*.[65] Here it was held by the majority that Mr Edwards, a defendant in criminal proceedings who had mental incapacities but who was competent to stand trial, should not be permitted to defend himself because there was a significant risk that in doing so he would humiliate himself and harm his dignity. Dissenting, Justice Scalia argued that 'The loss of dignity the sixth amendment right is designed to prevent is not the defendant's making a fool of himself…rather the dignity at issue is the supreme human dignity of being master of one's fate.'[66] This version of dignity requires a restriction on the freedom of individuals to make choices about how to live their lives in order to protect them from what others view as humiliating and undignified. Feldman notes that 'the notion of dignity can easily become a screen behind which paternalism and moralism are elevated above freedom in legal decision making.'[67]

Beyleveld and Brownsword explain that dignity as constraint is evident in legislation setting out the regulatory framework for biosciences where it may be used to limit what is permissible within the fields of, for example, human genetics and medical research, even where this involves the consent of those involved.[68] Here it is primarily what Feldman identifies as 'dignity of the species' which is at stake. Likewise in cases involving the 'right to die' the dignity of the species finds expression in the need to protect life. As Millns notes, the ECtHR has suggested, in these cases, that 'the dignity of humanity expressed in its most universal and objective form so as to protect life is given force over and above the individual and subjective dignity of the person seeking assistance to terminate a state of personal suffering.'[69] The use of dignity in these contexts is explored in greater detail in the following chapter.

Substantive meanings

Thus far this chapter has considered some of the key distinctions between the ways in which dignity is deployed in law. The next two chapters will look more closely at the meanings ascribed to dignity and what, therefore, dignity requires, in health care and equality law

[65] *Indiana v. Edwards*, 554 U.S. 164, 176 (2008)
[66] Ibid. at 186-7.
[67] Feldman (1999), note 9, above, at 696.
[68] Note 44, above.
[69] Millns, S. 'Death, Dignity and Discrimination: The Case of Pretty v. United Kingdom', 3(10) *German LJ* (2002), cited in McCrudden, note 1, above.

contexts. Before going on to do this, however, the chapter will conclude by surveying briefly some of the issues with which dignity is particularly closely associated as these will be helpful in organising the different meanings of dignity which emerge from a more detailed consideration of its legal uses in later chapters. Andrew Clapham suggests that legal concern with dignity has four main aspects. These are: 'the prohibition of all types of inhuman treatment, humiliation, or degradation by one person over another; the assurance of the possibility for individual choice and the conditions for 'each individual's self-fulfilment', autonomy, or self-realization; the recognition that the protection of group identity and culture may be essential for the protection of personal dignity; and the creation of the necessary conditions for each individual to have their essential needs satisfied.'[70] The second and fourth of these – autonomy and the satisfaction of essential needs have already been considered briefly above.

Freedom from humiliation is strongly associated with dignity. As will be seen in chapter seven, it forms part of the test for statutory discriminatory harassment in the UK and it has played an important role in the jurisprudence on Article 3 of the ECHR which prohibits torture or inhuman or degrading treatment or punishment. Dignity has been particularly prominent in the analysis of the treatment of prisoners in relation to Article 3,[71] but has also featured in cases which have considered whether requiring an individual to endure a particular state of poor health (because of a prohibition on assisted suicide, for example, or a withdrawal of treatment) amounts to inhuman or degrading treatment.[72] Dignity as freedom from humiliation has also featured in a number of other contexts to permit paternalistic protection from treatment of behaviour which – even though chosen – may in the eyes of the community reduce the dignity and standing of the individual (as in *Indiana*, above, and in *Seldon,*[73] discussed in chapter seven, where the need to protect an individual employee from potentially humiliating capability procedure was accepted as a reason capable of justifying mandatory retirement from a law partnership).

As well as these specific instances of humiliating or degrading treatment, dignity is also strongly associated with the communication of respect or value. Khaitan, for example, argues that the unique contribution human dignity can make, distinct from other values, is as an

[70] Clapham, A. (2006) *Human Rights Obligations of Non-State Actors* (OUP, Oxford) at p.545-6.
[71] See discussion and examples in McCrudden, note 1, above.
[72] See, for example, *Pretty v United Kingdom* [2002] 35 EHRR 1; *R (Nicklinson) v Ministry of Justice* [2015] AC 657; *Burke* v *General Medical Council* [2004] EWHC 1879 (Admin); and *D v United Kingdom* [1997] 24 EHRR 423 (discussed in Chapter 6).
[73] *Seldon* v *Clarkson, Wright and Jakes (a Partnership)* [2012] UKSC 16

expressive norm: 'Dignity appears to be indeterminate because it is in fact a single label for very different norms that, nonetheless, have one common presupposition: that meanings expressed by actions matter morally.'[74] On this view, many types of actions may, in addition to any other harms they involve, also violate dignity by communicating that the individual(s) is not valued, or is valued less highly than others. Some actions such as racist harassment may communicate this lack of value immediately and obviously; but so too may treatment which falls into Clapham's other categories. Thus, arguably, treatment which fails to respect the autonomy of the individual, or which leaves an individual or group without the basic means of subsistence, or which fails to recognise individuals or groups, will also convey a message that those individuals or groups are less valued than others.[75]

Clapham's fourth category of dignity - recognition – is also closely linked to the idea of the expressive meaning of action and is particularly associated with non-discrimination. Clapham refers here to the recognition of group identity and culture as necessary for the protection of dignity. This reflects the idea that recognition of difference is essential to achieve substantive equality which may require different treatment for particular groups in order to remedy past disadvantage or to preserve distinct cultural identity. 'Recognition dignity' is also linked to the recognition of the individual personality, distinct from any group to which the individual may happen to belong. Rao, for example, argues that the politics of recognition involves the claim that 'essential human dignity requires recognition of individual uniqueness in order to be fully respected. Unlike the dignity of being left alone to make one's own choices, the dignity of recognition is the demand of being *accepted* by the political, social, and moral community.'[76] Thus stereotyping and prejudice, classic instances of discriminatory behaviour, are an affront to this form of dignity because they fail to recognise the unique qualities and merits of the individual. Recognition is also associated with the idea of the development of personality, particularly in some jurisdictions.[77] As Taylor has explained, the politics of recognition is premised on the idea that 'our identity is at least partly shaped by

[74] Khaitan, T. (2012) 'Dignity as an Expressive Norm: Neither Vacuous Nor a Panacea' *Oxford Journal of Legal Studies* 32, 1-19; Likewise Dworkin has argued that '[t]he fundamental human right, we should say, is the right to be treated with a certain *attitude*: an attitude that expresses the understanding that each person is a human being whose dignity matters…Someone's most basic human right, from which all the other human rights flow, is his right to be treated by those in power in a way that is not inconsistent with their accepting that his life is of intrinsic importance.' In (2006) *Is Democracy Possible Here?* (Princeton University Press)

[75] For elaboration of this view see, for example, Reaume, D. (2013) 'Dignity, Equality and Comparison' in Hellman, D. and Moreau, S.(ed.'s) *Philosophical Foundations of Discrimination Law* (OUP, Oxford); and Moreau, S. (2004) 'The Wrongs of Unequal Treatment' *University of Toronto Law Journal* 57(2) 291-326.

[76] Rao, note 46 above, at p.249.

[77] Rao, ibid; Dupre (2009) note 6, above.

recognition or its absence or misrecognition by others, so a person can suffer real damage if society/others mirror back a degrading or confining picture of themselves.'[78]

The evolution of legal rights to same-sex marriage provides a good illustration of dignity as recognition. It was evident in the decision of the Court of Appeal of Ontario in *Halpern v Attorney General* which made the link between dignity and the public recognition and approval of marital relationships and held that exclusion from marriage of same sex couples 'perpetuates the view that same sex relationships are less worthy of recognition than opposite sex relationships. In doing so it offends the dignity of persons in same-sex relationships.' [79] This affront to dignity may occur even where there is no other difference in the legal rights between the parties and no economic loss involved. The differences between marriage and other forms of legal recognition of same sex partnership are argued to be significant – and wrong - precisely and only because they express the view that same sex couples are less worthy of recognition.[80]

Conclusion

This chapter has sketched some of the key distinctions in the uses of dignity by Courts and lawmakers and by those attempting to theorise the concept. The boundaries between these distinctions are messy, as should be evident from the above discussion. There are many conceptions of dignity, some of which are compatible with each other but some of which are not. Where they are not, a choice must be made as to which conception of dignity is to be deployed in order to resolve the legal question at issue. The next two chapters now look in more detail at the range of meanings attributed to dignity in the two legal contexts most relevant to age discrimination in health care – health care law and equality law.

[78] Taylor, C. (1994) 'The Politics of Recognition' in Gutmann, A. (ed) *Multiculturalism: examining the politics of recognition* (Princeton University Press, Princeton).
[79] (2003) 65 OR (3d) 161, CA for Ontario at para. 107.
[80] For discussion of this issue see Khaitan, note 74 above. See also opinion of Cory J in *Egan v Canada [1995] 2 SCR 513* where he argued 'The denial of [state] recognition may have a serious detrimental effect upon the sense of self-worth and dignity of members of a group because it stigmatizes them even though no economic loss is occasioned' (at 170).

CHAPTER SIX: DIGNITY AND HEALTH CARE LAW

Introduction

Having identified, in the last chapter, the main distinctions evident in legal (and some non legal) uses of dignity, this chapter now turns to look more closely at the uses and meanings of dignity in one context of close relevance to the issues identified in the first part of the thesis – the provision of healthcare.

Dignity is used extensively in current policy debates around various aspects of health care provision. Thus, for example, of particular relevance for the purpose of this thesis, and as will be seen below, a lack of respect for dignity is commonly identified as the wrong of age discrimination in a health care setting and as *a* key if not *the* key principle which should guide patient care, particularly of the elderly. Dignity also features prominently in several pieces of legislation governing the scope of medical research and intervention and in some key judgments on the most difficult aspects of medical care. It has generated much interest and debate among medical practitioners, ethicists and lawyers as to its utility and meaning, as well as calls for further work in this area.[1]

This chapter will look at the ways dignity has been used in some important cases on different aspects of health care provision in order to identify the different meanings attributed to it in this context and the way in which it relates to other relevant rights such as autonomy. It also considers, briefly, the empirical literature which has attempted to discover what dignity means to those involved in the provision and receipt of health care, and the theoretical debates about its use and meaning in a medical and bioethical context. It is organised into three main sections, each of which considers the uses of dignity in relation to one of three, overlapping, aspects of health care provision. These are bioethics and biolaw, resource allocation and patient care.

Dignity in Bioethics and Biolaw

Dignity plays an increasingly significant role in bioethics and biolaw.[2] It features prominently in ongoing ethical debates on a number of difficult and controversial issues

[1] Horton, Richard (2004) 'Rediscovering human dignity' *Lancet* 364, 1081-5.
[2] See generally Beyleveld, D. and Brownsword, R. (2001) *Human Dignity in Bioethics and Biolaw* (Oxford, OUP); Foster, C. (2011) *Human Dignity in Bioethics and Law* (Hart, Oxford); Hayry, M. (2004) 'Another Look

including assisted conception and abortion[3], genetic manipulation[4], medical research including the use of body parts[5], withdrawal of treatment[6] and the right to die.[7] So too dignity appears in the foreground of international instruments governing biomedicine and medical research.[8] Thus, for example, the Oveido Convention[9] resolves to 'take such measures as are necessary to safeguard human dignity and the fundamental rights and freedoms of the individual with regards to the application of biology and medicine'[10] Dignity has also been explored by the courts in a number of well publicised and controversial decisions on various aspects of the provision or withdrawal of medical care, several of which are considered in detail below.

As in other contexts, there is a lack of consensus on both the utility of and the substantive meaning of dignity. On the one hand Foster, a strong advocate for dignity in bioethics, has argued that other analytical tools and values traditionally deployed in situations which raise difficult bioethical issues are incapable, without more, of resolving those issues. The analytical tools to which he refers include the four Beauchamp and Childress principles (autonomy, non-maleficence, beneficence, justice) which have provided a framework for ethical decision making.[11] He argues that these principles – and particularly autonomy which has arguably emerged as the single most important principle in medical ethics[12] - are not

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at Dignity' *Cambridge Quarterly of Healthcare Ethics* 13, 7–14; Ashcroft, R. (2005) 'Making Sense of Dignity' *J Med Ethics* 31, 679–682; Killmister, S. (2010) 'Dignity : Not such a useless concept' *J Med Ethics* 36, 160-164; Dwyer D (2003) 'Beyond Autonomy: The Role of Dignity in Biolaw' *Oxford Journal of Legal Studies* 23(2), 319-331; Wheatley S. (2001) 'Human rights and human dignity in the resolution of certain ethical questions in biomedicine' *European Human Rights Law Review* 3, 312-325.

[3] Ashcroft, ibid; Binchy, W. (2014) 'Human Dignity and the Unborn Child – a Comment' *Medico-Legal Journal of Ireland* 20(2).

[4] Beyleveld, D. and Brownsword R. (1998) 'Human Dignity, Human Rights and Human Genetics' *Modern Law Review 5*, 661-680.

[5] Foster, C. (2014) 'Dignity and the Ownership and Use of Body Parts' *Cambridge Quarterly of Healthcare Ethics* 23, 417-430.

[6] Dupre, C. (2006) 'Human Dignity and the Withdrawal of Medical Treatment' *European Human Rights Law Review* 6, 678-694.

[7] Biggs, H. (2001) *Euthanasia: Death with Dignity and the Law* (Oxford, Hart); Allmark P. 'Death with Dignity' (2002) *J Med Ethics* 28, 255-257.

[8] Beyleveld and Brownsword, note 2, above.

[9] The Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human rights and Biomedicine (Oveido Convention) 1997.

[10] Ibid. Preamble. See also Article 1 which provides that 'Parties to this Covention whall protect the dignity and identity of all human beings…'; see also the Additional Protocols to the Oveido Convetion on Biomedical Research (2005), on the Prohibition of Cloning Human Beings (1998), on Transplantation of Organs and Tissues of Human Origin (2002) and on Genetic Testing (2008) all available at http://conventions.coe.int/Treaty/en/Treaties. See also The UNESCO Universal Declaration on the Human Genome and Human Rights 1997 and the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research involving Human Subjects 1964, readopted 2008.

[11] Beachamp T., and Childress J. (2012) *Principles of Biomedical Ethics* (*7th Edition*) (Oxford, OUP).

[12] See also Herring, J. (2012) *Medical Law and Ethics* (Oxford, OUP) p. 24.

capable of resolving some of the most difficult bioethical dilemmas; and that even when they appear to be have been successfully deployed in doing so, it is really dignity that is doing the work behind them. 'The sound of a good choir is greater than, and different in quality from, the sum of its parts. And my suggestion here is that the sound of a well-tuned Beauchamp and Childress choir is the voice of dignity.'[13] For Foster, the meaning of dignity can be discovered by determining what it is that makes humans thrive. He acknowledges that this is not the meaning currently ascribed to dignity by the courts but that, on the other hand, the meanings ascribed to dignity by the courts are not incompatible with it. He proposes a weighing of the dignity impact of any decision on all parties affected by it in order to make the right decision in difficult bioethical cases and argues that '[d]ignity is the key that, properly wielded, unlocks all problems in medical ethics and bioethics. It is the bioethical Theory of Everything.'[14]

On the other hand, there are a number of dignity sceptics who are concerned that, at best, dignity serves no useful purpose in bioethics and law.[15] A common charge is that dignity adds little or nothing to the existing, firmly established, principle of autonomy and the dominant paradigm of informed consent around which much bioethical and legal discussion is already organised.[16] In part the dignity/autonomy debate centres around the difficult issues of who has dignity rights or interests. Conceptions of dignity which equate dignity with capacity for autonomy or agency (whether autonomy gives rise to dignity or dignity gives rise to autonomy or both) have work to do to explain whether and why those who lack the capacity for autonomy - such as foetuses and those in persistent vegetative state - have dignity interests at all.[17] In addition, and as will be seen below, courts have often raised dignity and autonomy rights together without qualifying the nature of the relationship between them, making it difficult in some circumstances to detect what work is being done by autonomy and what by dignity.

Beyleveld and Brownsword, as discussed in the last chapter, have argued that the most important distinction in the uses of dignity in biolaw and ethics (and indeed generally) is

[13] Foster, note 2, above, p.3.
[14] For a critical view of Foster's approach see Brownsword, R. (2012) 'Charles Foster: Human Dignity in Bioethics and Law' *Medical Law Review* 20 246-253; Coggon, J. (2012) 'Human Dignity in Bioethics and Law by Charles Foster' *Journal of Law and Society* 39(4), 625-630.
[15] See, for example, Bagaric, M. and Allan, J. 'The vacuous concept of dignity' (2006) 5(2) *Journal of Human Rights* 257-270; Macklin, R. (2003) 'Dignity is a useless concept' *British Medical Journal* 327: 1419.
[16] Beyleveld and Brownsword, note2, above.
[17] ibid.

between dignity as empowerment and dignity as constraint: 'Where human dignity as empowerment holds court, and autonomy is prioritised, bioethics is organised largely around the notion of informed consent. On the other hand, where human dignity as constraint rules, and either paternalism or social defence prevails, consent (no matter how free or informed) is no longer decisive.'[18] They argue that the new bioethics, as reflected in international instruments governing biomedicine, reflects a dominance of dignity as constraint and, as a result, is more concerned with duties than rights. Dignity acts as an 'umbrella' for this duty driven approach which involves a duty to respect the dignity of others, a duty not to compromise our own dignity and a duty 'to act in a way that is compatible with respect for the vision of human dignity that gives a particular community its distinctive cultural identity.'[19] This is perhaps most evident of all in approaches to technological advancement, and particularly use of genetic material, where the autonomy of the individual is trumped by the duty to respect the dignity and integrity of the human species.[20]

Dignity has featured in a number of the most well publicised medical law cases in the UK and the ECtHR, although nowhere has the meaning of dignity been set out clearly by the courts. The following section looks at the ways in which dignity has been used in a number of cases raising difficult bioethical issues. It aims to identify both the meanings (if any) ascribed to dignity by the courts and the ways in which dignity is used, particularly in relation to other rights such as autonomy.

Death with dignity

Perhaps the most familiar use of dignity in bioethical debate is in relation to death.[21] Indeed Dignity has been the key value espoused by campaigners for changes to the law on assisted dying.[22] Dignity has also featured in judicial consideration of the circumstances under which life sustaining treatment may be refused or withdrawn or active assistance given to shorten life for the terminally ill.

In *Airdale NHS Trust v Bland*[23] the courts were required to consider whether artificial life support could be lawfully withdrawn from a patient in a persistent vegetative state (PVS). Tony Bland, one of the victims of the Hillsborough disaster, had remained in PVS for three

[18] Ibid. p. 11.
[19] ibid. p. 29.
[20] Ibid; See also Feldman, D. (1999) 'Human dignity as a legal value: Part 1' *Public Law, Win,* 682-702.
[21] Biggs, H., note 10, above; Allmark, P., note 10, above.
[22] See, e.g. www.dyingindignity.org.uk
[23] [1993]AC 789;

years, with no prospect of improvement, when the hospital authorities sought a declaration as to whether it would be lawful to cease to provide artificial means to keep him alive. The House of Lords upheld the decisions of the lower courts that it would indeed be lawful so to do. The House of Lords did not discuss dignity at any length in the course of its deliberations,[24] but the Court of Appeal, in reaching the same conclusion as the House of Lords, did. Hoffmann LJ (as he was then) explained the significance of dignity in the course of his assessment of the weight that should be given to the principle of the sanctity of life in reaching a determination of the question before the court:

> 'But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person…No one, I think, would quarrel with these deeply rooted ethical principles. But what is not always realised, and what is critical in this case, is that they are not always compatible with each other.'[25]

There are a number of points to make about Hoffmann's use of dignity here. First, dignity appears to be something distinct from autonomy and, indeed, something which may on occasion be incompatible with it. On Hoffmann's account, respecting dignity does not appear to require respecting autonomy, or vice versa. The distinction between dignity and autonomy is further reinforced by the context. Hoffmann is clear that that Bland had dignity interests in the manner of his own life and death – that it should not be humiliating - even though he had no consciousness of it.[26] He suggests, then, that dignity has a community meaning, one which requires or prohibits certain treatment or standards of behaviour – those which do not respect the value of the individual - even in the absence of agreement, or even awareness, on the part of the recipient. This is not to suggest that, for Hoffmann, dignity trumps autonomy.

[24] Lord Goff did suggest that account should be taken of the indignity to which Bland would be subject should the treatment continue but it was the futility, rather than the indignity, of the treatment which proved decisive (ibid. at 869).
[25] ibid. at 826.
[26] But see Finnis, J. (1993) 'Bland: crossing the Rubicon?' *Law Quarterly Review* 109, 329-337, who draws a distinction between undignified treatment by others and conditions of indignity the latter of which, he argues, cannot be protected against.

Indeed he goes on, later in his speech, to consider the potentially overriding significance of Bland's wishes – his express wishes had they been known or the court's best guess as to what his wishes would have been in the absence of any express wishes – to determine the answer to the issues with which the court was faced. However, the question about what Bland would have wished appeared to be a separate question from the question of what dignity requires.[27] On the facts of this case there was no conflict between the demands of dignity and autonomy. Autonomy would suggest artificial life support should be withdrawn because that is the best guess at what Bland would have chosen. Dignity comes to the same conclusion because 'we think it would show greater respect to allow him to die and be mourned by his family than to keep him grotesquely alive.'[28] In the event there had been conflict between these two principles however, it is not clear how the court would have resolved them. There is certainly no suggestion that dignity would automatically have trumped autonomy. It is a shame that the 'close connection' between the principles was not further elaborated.

Second, and following on from the first issue, Hoffmann suggests that dignity has no special status as an overarching principle – either a foundational principle or a principle at the top of a hierarchy – but that it is merely one of a number of competing principles. Counsel for Mr Bland had attempted to argue that the sanctity of life had to be interpreted in the light of the demands of respect for the dignity and memory of the individual concerned. Lord Hoffmann specifically rejected attempts to make sanctity of life compatible with dignity by reading the requirements of dignity into what is meant by 'life.' He preferred to conceive of them as separate, potentially incompatible, principles and to deal with any potential clash between them head on.[29]

Third, and in relation to its substantive meaning, dignity is closely linked throughout with privacy, bodily integrity and freedom from humiliation and distress caused by both external (treatment by others) and internal (feelings aroused by illness and its consequences). Butler Sloss LJ, who concurred with Hoffmann, cited with approval the judgment of Handler, J in *In re Conroy* in her analysis of what would be wrong in keeping Bland alive: 'Eventually, pervasive bodily intrusions, even for the best of motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human

[27] Though see the discussion in Beyleveld and Brownsword, note 2 above, who advocate an interpretation of the judgment which anchors the dignity analysis firmly to Bland's right to choose.
[28] Note 23, above, at 830.
[29] Ibid. at 827. The focus of the discussion was on clash between autonomy on the one hand and sanctity of life on the other, with suggestion that autonomy should be decisive here.

dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.'[30] Again she suggests that dignity may be infringed even in the absence of consciousness (and therefore of humiliation and distress as normally understood).

Some fifteen years after *Bland*, the ECtHR raised dignity in its deliberations on assisted dying in *Pretty v United Kingdom.*[31] The applicant, who suffered from motor neurone disease, had sought, and been refused, an undertaking from the Director of Public Prosecutions that her husband would not be subject to criminal prosecution should he assist her in ending her life as the disease reached its final stages. She argued that she wished to control the manner and timing of her death in order to avoid the suffering and indignity to which she would otherwise be subject and that the refusal of the DPP to grant the undertaking was in breach of her rights under Articles 2,3,8 and 14 of the ECHR. The European Court agreed with the UK Courts that her Convention Rights had not been breached. However they held that that choosing the manner of one's death could be accepted as part of right to private life protected under article 8:[32]

> 'The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.'[33]

The court concluded that the applicant's inability to choose to avoid indignity and distress may constitute an interference with her Article 8 rights. Having determined the Article 8 was engaged, however, the Court decided that any interference with the applicant's rights were justified under 8(2) and that states were to be afforded a wide margin of appreciation in this regard. Dignity did not feature in the court's analysis of proportionality which was presented as a weighing of the autonomy of the individual against the very serious risk to public health and safety which would be afforded by a relaxation of the prohibition on assisted suicide. In

[30] ibid at 821, citing *In re Conroy* [1985] 486, A.2d 1209, per Handler J at 1249.
[31] [2002] 35 EHRR 1.
[32] It was held that the Article 2 right to life did not include a right to die; and that in the circumstances the state was not inflicting treatment in breach of its obligations under Article 3. Cf *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, where the Court of Appeal held that Article 3 may be infringed where lack of treatment or treatment causes suffering in death; See also *R (Purdy)* v *Director of Public Prosecutions* [2009] UKHL 45, discussed further beow.
[33] Note 31, above, at 65.

the circumstances the court held that a blanket ban on assisted suicide was not disproportionate. In *Pretty* again, then, dignity is related closely to the distress which may be caused by the physical and mental condition in which a patient my find themselves. The need to preserve dignity is presented as a reason for preserving autonomy – but not as an overriding reason.

The court also refers, here, to ideas of self and of personal identity. Personal identity, and personality, which have been recognised by the ECtHR to be protected by article 8,[34] have been linked closely with dignity in a number of jurisdictions including Germany and Hungary.[35] Dupre explains that the right to personality is 'a kind of umbrella right that acknowledges the uniqueness of each of us by protecting a wide range of activities and interactions between people' and argues that personality and dignity cannot (and should not) be easily distinguished from one another. Recognising, and protecting, personality and identity has been held to include the right to find one's biological parent, the freedom to marry without permission from a superior officer and the right to an NHS pension for the transgender partner of an employee.[36] In a bioethical context it has also featured in the debate on aspects of reproductive medicine (and genetics), discussed further below. In *Pretty* it may, perhaps, be interpreted as an interest in preserving aspects of identity under threat from external forces of disease and medical intervention, by choosing not to continue to live.

The most recent judicial pronouncement on assisted dying in the UK Courts came in *R (Nicklinson) v Ministry of Justice.*[37] Nicklinson had been paralysed by a stroke. His condition was not terminal but he described it as 'demeaning, undignified and intolerable.' He wished to die and required assistance to do so. Without assistance his only means of killing himself was the refusal of nutrition, something he had argued was likely to involve considerable pain and distress. Nonetheless, following refusal of the relief he sought from the High Court, this is what he did. After his death, his case was then pursued before the appellate courts by his wife, together with a number of other applicants, each in a similar situation to that in which Nicklinson had been. The Supreme Court were asked to rule on whether the current state of the Law in the UK, and the guidance from the Director of Public

[34] *Niemietz v Germany* (1992) 16 EHRR 97 discussed in Dupre (2006) note 6, above.
[35] Dupre (2006) ibid.
[36] Dupre (2006) ibid; see also Jones, J. (2004) '"Common constitutional traditions": can the meaning of human dignity under German law guide the European Court of Justice?' *Public Law* Spr. 167-187.
[37] [2015] AC 657. See also Finnis, J. (2015) 'A British "Convention right" to assistance in suicide? Case Comment' *Law Quarterly Review* 131, 1-8; Wicks, E. (2015) 'The Supreme Court judgment in Nicklinson: one step forward on assisted dying; two steps back on human rights.' *Medical Law Rev*iew 23(1), 144-156.

Prosecutions, was compatible with the ECHR. As in *Bland*, dignity received relatively little attention in the Supreme Court.[38] There were, however, a number of interesting references to dignity in the Court of Appeal which had been invited to consider whether a common law defence to murder in cases of assisted dying could be built on common law rights to dignity and autonomy. Giving the leading judgment Dyson LJ and Elias LJ expressed some doubt that an independent common law right to dignity and autonomy exists in English law; rather dignity and autonomy serve as values or principles which inform interpretation of other common law rights such as privacy and self-determination. In any event, they held that even if there were common law rights to dignity and autonomy it was 'manifestly correct' that autonomy and dignity may need to yield to other principles or interests, in particular the sanctity of life: 'the sanctity of life is if anything an even more fundamental principle of the common law, reflected in the unqualified right to life found in Article 2 of the Convention…there is no self-evident reason why it should give way to the values of autonomy or dignity and there are cogent reasons why sensible people might properly think that it should not.'[39]

While judicial comments on dignity in these end of life cases do not provide a clear and coherent account of its meaning and use, two features stand out. First, although apparently closely linked with autonomy, dignity is related more closely to the impact of continued life on mental and physical well-being and on the individual patient's sense of identity. The emphasis seems to be not on the impact on dignity of the denial of choice per se, but from the consequences of the only available option – continuing to live in the altered and distressing circumstances – for the patient. Second, dignity is treated as an interest or a right (whether at common law or as a constituent of the Article 8 rights) which is capable of being trumped by other, equally or more important rights or interests. It has not been used as a principle or value to interpret the requirements of other rights nor to weigh up competing interests when these conflict. There is no evidence of its use – in the cases above - as a foundational principle from which other principles – autonomy, sanctity of life, depend and fall to be interpreted.

[38] Though Lord Sumption, ibid. at 824, commented that '[t]he principle of autonomy is one of these values. Its basis is the moral instinct, which is broadly accepted by English law subject to well-defined exceptions, that individuals are entitled to be the masters of their own fate. Others are bound to respect their autonomy because it is an essential part of their dignity as human beings.' Approving the approach of Lord Hoffmann in *Bland* he went on to note that autonomy and dignity are not compatible with sanctity of life where an individual wishes to end their life.

[39] Ibid. at 714.

Withdrawal of Treatment against the wishes of the terminally ill patient

Another interesting use of dignity has been in two cases which concern the wishes of terminally ill patients to continue to be provided with particular treatments or with resuscitation. The general position in English Law is that patients do not have a right to any particular treatment although doctors are under legal duties to provide non-negligent care and to make treatment decisions in the best interests of non-competent patients.[40] However, in *Burke* v *General Medical Council* the courts were asked to consider whether a patient's wish to continue to receive treatment once they were no longer conscious and near death should be determinative.[41] Leslie Burke had spinocerebellar ataxia, a condition which would result in his eventual death. It was likely, though not inevitable, that at the very final stages of his life he would, for a short while, be sentient but unconscious and thus unable to communicate his wishes or be competent to consent. The case arose from his desire to ensure that in such circumstances he would continue to be provided with artificial nutrition and hydration ('ANH') until he died as a result of the natural course of his condition. He was anxious to ensure that he would not be subject to the distressing symptoms a withdrawal of ANH would produce and was concerned that the relevant Guidance from the General Medical Council did not preclude the withdrawal of ANH from terminally ill and incompetent patients where it was judged to be in the best interest of the patient to do so. Burke argued that the Guidance was unlawful and contrary to articles 2, 3, 8 and 14 of the ECHR. Munby J, in the High Court, agreed that the refusal of a hospital to provide ANH to a patient who had requested it would be a breach of articles 3 and 8. The Court of Appeal reversed this decision and the ECtHR refused an application.

Dupre, notes that the judgment of Munby in the High Court was the first in English Law where dignity played a fully central role.[42] Munby spent a lengthy portion of his speech assessing the role of both dignity and autonomy in relation to Article 8 before concluding that, in determining what would be in Mr Burke's best interests once he was no longer competent, the medical team should be required to respect his expressed wishes to continue with ANH. There are a number of interesting features of the use of dignity in the judgment. First, as in the cases discussed already, dignity again appears distinct from autonomy, both being important and related but separate principles. According to Munby, autonomy includes

[40] Herring, J. (2012) *Medical Law and Ethics* (Oxford, OUP); Newdick, C. (2005) *Who Should We Treat? Rights, Rationing and Resources in the NHS* (OUP, Oxford).
[41] [2004] EWHC 1879 (Admin).
[42] Dupre (2006) note 6, above.

choice of how to spend last days and manage death. Dignity, on the other hand, includes a right to die with dignity - a right to be protected from treatment (or lack of it) which results in dying in distressing circumstances and threatens mental stability at the very end of life. He notes, as did Hoffmann in *Bland,* who he cites with approval, that even those who no longer have consciousness may have dignity interests. He also stresses that what amounts to dignity at the end of life will not be the same for everyone: 'we have to remember that views as to what is dignified or undignified are highly personal. What is dignified to one may be undignified to another. And vice versa. So, as Ms Rose correctly observes, we must guard against assuming that ANH is in all circumstances a good thing conducive to human dignity merely because that is, if indeed it is, the claimant's strongly held view.'[43] Thus it is for each individual, as far as possible, to decide what conditions will be conducive to dignity at the end of life. It is not something that a medical team can determine in the absence of the wishes of the patient, although where it is impossible to know the patient's wishes they will have to do their best.

The decision and reasoning of the High Court was controversial as it appeared to found a right to particular treatment and was duly overturned by the CA who noted that 'autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.'[44] Dignity is not mentioned in the judgment, nor in the judgment of the ECtHR. Dupre is highly critical of the absence of dignity analysis in the CA and (apparently ignoring their own jurisprudence in *Pretty*) the ECtHR and expressed concern at the time that these omissions 'seem to have put an end to development of this concept in relation to the withdrawal of medical treatment.'[45]

Despite these fears, however, dignity has featured in another very recent case, *Tracey v Cambridge University Hospitals NHS Trust*[46] which concerned not the withdrawal of ongoing medical treatment but, perhaps comparable in important respects, a decision not to resuscitate a terminally ill patient which was taken without the knowledge or consent of the patient herself. Mrs Tracey had terminal lung cancer when she was admitted to hospital following a car crash with serious respiratory failure. The medical team placed a 'Do not

[43] Note 41, above, at 66.
[44] Note 32, above, at 296.
[45] Dupre (2006) note 6 above at 679.
[46] [2014] EWCA Civ 822.

attempt cardio pulmonary resuscitation' ('DNACPR') notice on her file without consultation with Mrs Tracey or with her family. Her family complained when they discovered this and the notice was removed. Her condition deteriorated and a second DNACPR notice was placed on file, this time with the consent of her family, though not with Mrs Tracey who was, by that stage, refusing to discuss her treatment with the medical team. She died two day later.

The main issue in the case was whether the lack of consultation with Mrs Tracey about the first DNACPR notice was in breach of her Article 8 rights, and to establish the extent of a doctors duty to consult in such circumstances. The Court of Appeal noted that *Pretty* had established conclusively that Article 8 was indeed engaged where matters concerning end of life procedures are involved. It was held that consultation was an integral part of protecting the dignity interests of the patient which are protected by Article 8 (the duty to consult in such circumstances also being protected by common law): 'The duty to consult which this court has described involves a discussion, where practicable, about the patient's wishes and feelings that is better undertaken at the earliest stages of the clinical relationship so that decisions can be reviewed as circumstances change. That involves an acknowledgement that the duty to consult is integral to the respect for the dignity of the patient.'[47] The Court did concede that the doctor's duty to involve the patient in making this type of decision did not extend to circumstances where consultation was likely to cause physical or psychological harm to the patient. It was stressed, however, that doctors should be wary of excluding patients from the process through concern that it may distress them.[48] It is worth noting that, consistent with their decision in *Burke*, the Court stressed that the duty to consult should not be confused with an obligation to provide a certain form of treatment. The patient has no right to insist on a particular form of treatment, though they may refuse it.[49]

This approach reflects that taken recently by the Supreme Court to the scope of the doctor's duty to provide a patient with information on risks of a particular treatment and on the alternative courses of treatment in order to meet the duty of care in medical negligence cases. In *Montgomery* v *Lanarkshire Health Board* the Court stressed that, other than in very exceptional circumstances, a doctor would be expected to provide such information on risks and alternatives as a prudent patient would require because 'respect for the dignity of patients

[47] Ibid. at 99.
[48] ibid. at 54.
[49] ibid. at 97.

requires no less.'[50] Again, doctors would not be required to do so where this would involve serious psychological harm to the patient but it was stressed that this exception to the general principle should not be used in order to enable a doctor to prevent the patient making an informed choice to act against what the doctor perceived to be their best interests.[51]

A final interesting use of dignity in the UK case law on bioethical issues has been in relation to reproductive rights. In *Evans v Amicus Healthcare*[52] the claimant wished to use embryos created and stored, with the full consent of her (then) partner, prior to undergoing medical treatment which would leave her infertile. Her partner had assured her at the time that he would not later withdraw consent for the use of the embryos and as a result she had not explored the option of having her eggs preserved. When the relationship later broke down her partner withdrew his consent for her to use the frozen embryos, which was now her only chance of becoming a biological parent. The Court of Appeal dismissed her appeal against a High Court decision that she was not entitled to use the embryos. In her assessment, however, Arden LJ did note that '[i]nfertility can cause the woman or man affected great personal distress. In the case of a woman, the ability to give birth to a child gives many women a supreme sense of fulfilment and purpose in life. It goes to their sense of identity and to their dignity.'[53] When the case reached the European Court of Human Rights the majority rejected her appeal, noting that '[r]espect for human dignity and free will as well as a desire to ensure a fair balance between the parties to IVF treatment, underlay the legislature's decision to enact provisions permitting of no exception to ensure that every person donating gametes for the purpose of IVF treatment would know in advance that no use could be made of his or her genetic material without his or her continuing consent.'[54] Dignity also featured in the dissenting opinions of Judges Türmen, Tsatsa-Nikolovska, Spielmann and Ziemele, who noted that the legislation 'inflicts such a disproportionate moral and physical burden on a woman that it can hardly be compatible with Art. 8 and the very purposes of the Convention protecting dignity and autonomy.'[55] Thus dignity appeared on both sides of the argument. Its association with identity here reflects the meaning suggested for dignity by the ECtHR in *Pretty* discussed above. Here however dignity as identity was unhelpful to resolving the dispute as the identities of both parties were under threat - either by the loss of the chance to

[50] [2015] UKSC 11 at 93, per Lord Kerr and Lord Reed.
[51] ibid. at 91.
[52] *Evans v Amicus Healthcare and others (Secretary of State for Health and another intervening)* [2004] EWCA Civ 727.
[53] ibid. at 81.
[54] *Evans v United Kingdom* [2008] 46 EHRR 34 at 89.
[55] ibid. at O-114.

have a biological child should the appeal fail or by becoming a biological parent without consent should the appeal have succeeded.[56] It does raise, however, the question of what obligations the duty to protect identity may impose in other circumstances.[57]

Dignity and positive rights to health care

This section considers the extent to which dignity interests may be relevant in determining the scope of any positive obligation on the part of the state to meet health care needs. (The relationship between dignity and the equality/fair distribution aspects of resource allocation are considered in chapters seven and eight.) It was seen in the previous chapter that one approach to dignity rights (whether characterised as rights to dignity or rights flowing from dignity) is to argue that dignity entails a positive obligation to ensure each individual has access to the basic goods necessary to exercise autonomy or to live according to some other conception of a dignified life. However, in contrast to the literature on bioethics, dignity has not attracted much attention in the literature on the allocation of health care resources and indeed does not tend to feature much in the deliberations of the courts on these issues (as will be seen below.)[58]

Feldman argues that there are several reasons why dignity *should* play an integral part in health care resource allocation decisions. First, because the availability of health care may have a very significant effect on the ability of individuals to live a dignified life; second, because dignity is implicated in the need for a fair distribution of resources where each patient is worthy of equal respect and concern; and third because '…the idea of human dignity should require those who make resource allocation decisions in relation to health care to think of patients holistically and give consideration to resourcing their total care, rather than thinking of them simply in terms of the particular diseases from which they suffer.'[59]

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[56] See Foster (2011) note 2, above, chapter 10, for further discussion of this point. Foster also notes the increasing use of dignity language, and of dignity as identity, in decisions relating to abortion (although not in the UK or ECtHR).

[57] See Dupre (2006) note 6, above and (2009) 'Unlocking human dignity: towards a theory for the 21st century' *European Human Rights Law Review* 2, 190-205.

[58] Foster (2011), note 5, above, argues that academics worry about resource allocation for reasons which must be located in dignity, though they are not discussed in those terms, and that equally 'judicial distaste for weighing one life against another is a similar indication of an often undiagnosed belief in dignity.' (p.128) For an exception see McDougall, R., (2008) 'A resource based version of the argument that cloning is an affront to human dignity' *Journal of Medical Ethics*, 34, 259-261 who argues that the reason support for cloning is an affront to human dignity is not the reason(s) traditionally advanced in the bioethical debate but the fact that cloning diverts scarce resources from those whose unmet health care needs prevent them from being able to exercise their freedoms.

[59] Feldman, D. (2000) 'Human dignity as a legal value: Part 2' *Public Law* 61-76.

Feldman's first point – that healthcare (or certain forms of it) may be necessary to lead a dignified life – is certainly familiar from the approach to dignity as a foundation for social rights discussed in the previous chapter. It was seen that, in some jurisdictions (though not in the UK),[60] various forms of basic welfare entitlement have been founded on constitutional dignity guarantees. Thus, for example, Rao notes that this approach contrasts with that in the US where dignity arguments tend to emphasise autonomy and freedom from state intervention dignity rather than the dignity that stems from and requires the guarantee of minimum goods needed for basic welfare. These differences, she notes, are neatly reflected in the debate over healthcare reform and in particular the controversy over Obamacare. 'The Obama Administration expresses the imperative for government to address the indignity and needs felt by those who lack healthcare. Critics contend that requiring the purchase of healthcare insurance intrudes on the individual dignity that comes from making one's own choices with minimal interference by the State.'[61]

Allocation of Health Care Resources in the UK Courts

As Herring notes, challenges to health care rationing decisions in the UK are rarely successful: courts are unwilling to intervene where issues of resource allocation are concerned unless manifestly irrational.[62] Where Judicial Review succeeds it tends to be on procedural grounds rather than because a refusal of any particular treatment is substantively unfair. This is the case even where the treatment involved is potentially life-saving. Thus In *R v Cambridge* the Court of Appeal approved the decision of the health authority to refuse to fund expensive experimental treatment for a ten year old girl with leukaemia who would certainly die without it, because the substantial expenditure combined with the limited prospect of success meant it would not be a good use of resources.[63] Where challenges have succeeded they have tended to involve procedural failures such as, for example, a failure to adequately define what would constitute an exceptionality in relation to the refusal to provide

[60] Gearty notes that dignity has played a non-existent or at best peripheral role in recent cases involving socio-economic rights in the UK in Gearty, C. (2013) 'Socio-Economic Rights, Basic Needs and Human Dignity: A Perspective from Law's Front Line' in McCrudden, C. (ed) *Understanding Human Dignity* (Oxford OUP).
[61] Rao, N. (2012) 'American Dignity and Healthcare Reform' 35 *Harvard Journal of Law and Public Policy 171*
[62] Herring, J. (2012) *Medical Law and Ethics* (Oxford, OUP). See also Newdick, C. note 40, above; Feldman (2000) note 59, above; Foster, C. (2007) 'Simple rationality? The law of healthcare resource allocation in England' *J Med Ethics* 33, 404-7.
[63] *R v Cambridge Health Authority ex parte B* [1995] 2 All ER 129, CA.

an expensive cancer drug[64] or a policy which allowed no room for the exercise of discretion and consideration of individual facts in relation to gender reassignment surgery.[65]

The ECHR – and specifically Articles 2, 3 and 8 - will only very rarely found a positive right to treatment.[66] The Article 2 right to life has not been interpreted as giving rise to a duty to provide lifesaving treatment;[67] and in In *R v NW Lancashire* the claimant's attempt to argue that refusal to provide gender reassignment surgery breached Article 3 was roundly rejected by Buxton LJ as trivialising the seriousness of the circumstances necessary for Article 3 to be engaged (although he did not rule out the possibility that the refusal of treatment for some conditions may meet this standard.)[68] Likewise Article 8, which has proved a natural home for arguments invoking dignity in other contexts, has not been accepted as founding a right to a particular form of treatment and, as Foster notes, 'has some work to do to establish its resource allocation credentials.'[69] The ECtHR confirmed in *Senteges* and in *Pentiacova*[70] that Article 8 was generally not engaged in situations which involved a decision to not provide a particular form of treatment. This was followed in the UK by the Court of Appeal in *Condliff* where it was noted that '[a]lthough the Strasbourg Court has recognised that in principle Article 8 may be relied on to impose a positive obligation on a state to take measures to provide support for an individual, including medical support, there is no reported case in which the court has upheld such a claim by an individual complaining of the state's non-provision of medical treatment.'[71]

Dignity has played very little, if any, role in these deliberations. Counsel for the appellant in *Condliff* did invoke dignity in the course of his argument but this was not taken up by the Court. However, one important exception is the recent case of *McDonald* where both the House of Lords and ECtHR took an approach to the question of whether or not Article 8 was

[64] *R (on the application of Rogers) v Swindon NHS Primary Care Trust and another* [2006] EWCA Civ 392.
[65] *R v North West Lancashire Health Authority, ex p A, D &G* [2001] 1 WLR 977; See also Newdick, note 40, above, who argues that it is often not difficult for courts to find procedural flaws, should they be inclined to do so.
[66] Herring, J. note 62 above, p. 69.
[67] See discussion in Wicks, E. (2010) *The Right to Life and Conflicting Interests* (OUP, Oxford).
[68] Note 65 above. See, however, *D v United Kingdom* [1997] 24 EHRR 423, where it was held that the removal from the UK by the immigration authorities of an AIDS patient was in breach of Article 3 because of the nature of the desperate circumstances in which he would die if repatriated to St Kitts, where only wholly inadequate medical and other support would be available.
[69] Foster (2011), note 2, above, at p.133
[70] *Sentges v Netherlands* [2004] 7 CCL Rep 400; *Pentiacova v Moldova* [2005] 40 EHRR SE23.
[71] *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 at 41.

engaged which specifically invoked dignity.[72] Mrs McDonald, who had been a ballet dancer, had suffered a stroke. She was continent but needed assistance to get to and from the toilet due to her limited mobility. Because she normally needed to urinate two or three times during the night, the respondent authority had previously provided a night time carer to assist her in getting to and from a toilet during the night. They subsequently decided to remove this support and instead to provide Mrs McDonald with incontinence pads or special sheeting to avoid the need to visit the toilet during the night and thus the need for a night time carer. They argued that this met the applicant's needs which they had redefined to be for 'safe urination at night,' and argued that, to the extent they were under a duty to provide a service which enabled her to live with dignity, they had met this requirement. The Supreme Court, by a majority, found that there had been no breach of Article 8 with Hale offering a powerful dissent based largely on what she saw as an assault to Mrs McDonald's dignity. Mrs McDonald then appealed to the ECtHR. She argued, among other things, that the decision of the authority was in breach of the positive obligation under Article 8 to provide her with a service which enabled her to live with dignity. It is worth quoting a key passage of the ECtHR judgment in full:

> 'In *Pretty* the Court held that the very essence of the Convention was respect for human dignity and human freedom; indeed, it was under Article 8 that notions of the quality of life took on significance because, in an era of growing medical sophistication combined with longer life expectancies, many people were concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflicted with their strongly held ideas of self and personal identity (Pretty v. the United Kingdom , cited above). Although the facts of the present case differ significantly from those of Pretty , insofar as the present applicant believed that the level of care offered by the local authority would have undignified and distressing consequences, she too was faced with the possibility of living in a manner which "conflicted with [her] strongly held ideas of self and personal identity". In the Supreme Court, Baroness Hale, in her dissenting opinion, appeared to accept that considerations of human dignity were engaged when someone who could control her bodily functions was obliged to behave as if she could not (see paragraph 25 above). The Court agrees with this general assessment of the applicant's situation and it does not exclude that the particular measure complained of by the applicant in the present case was capable of having an impact on her enjoyment of her right to respect for private life as guaranteed under Article

[72] *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33; *McDonald v United Kingdom* [2015] 60 EHRR 1.

> 8 of the Convention. It therefore finds that the contested measure reducing the level of her healthcare falls within the scope of Article 8.'[73]

Having determined that Article 8 was engaged, however, the Court were careful to point out that while they were prepared to approach the case as one of interference into the applicant's right to a private life, they were not answering the question as to whether or not there existed a positive obligation on the part of the state to provide a particular level of care in this context. Further, and having found that there had been a prima facie interference with the applicant's Article 8 rights, the Court found that the interference was justified and proportionate. The Court noted the wide margin of appreciation afforded in cases relating to health policy and in particular the allocation of scarce resources. It also noted that the UK Supreme Court, in considering whether there had been a prima facie interference with Mrs McDonald's Article 8 rights, had effectively conducted a thorough proportionality analysis in weighing up the interests of Mrs McDonald against the needs of the wider community.[74]

One further point is of particular interest here in relation to dignity. In the Supreme Court the majority decided there was no interference with Article 8. They took the view that the respondent authority, in offering Mrs McDonald the incontinence pads, had in fact acted to protect her dignity interests. It was apparently of no import that Mrs McDonald's view of what dignity required was so different to that of the respondent. Lord Brown noted, in reaching this conclusion, that the respondent authority had gone to some lengths to consult with Mrs McDonald about the options they were able to offer and to seek to convince her that incontinence pads offered the best solution, not just on grounds of cost but as a means of securing her safety and privacy.[75] Here then, and in contrast to the observations of Munby LJ in *Bland*, the question of what conditions are necessary for the dignity of the individual patient appears to be a wholly objective one. Even Hale, in her dissent, did not argue that requiring a continent patient to use incontinence pads was an interference with dignity when the patient felt it to be so. Rather she argued that this approach fell short of the 'standards of a civilised society.'[76]

Dignity and patient care

[73] *McDonald v United Kingdom*, ibid. at 47.
[74] ibid. at 54-8.
[75] *R (McDonald) v Royal Borough of Kensington and Chelsea*, note 72 above, at 19.
[76] ibid. at 79.

One area where dignity features with increasing prominence is in research and policy debate on patient care. This includes both medical and social care and has included a particular focus on the care of older people both in hospital and in care homes. It is at the core of several of the key NHS policy documents which are intended to govern and guide clinicians in their provision of care and set minimum standards for basic care.[77] Lack of dignity is the diagnosis and dignified care the suggested solution in number of reports exposing poor care, particularly of the elderly, in hospitals and other care settings.[78] Despite this, and as noted in chapter one, it was decided not to include a principle based on dignity in care in the Health and Social Care Act 2012. The government had consulted as to whether dignity in care (and/or one of a number of other candidate principles) should be included as a statutory principle to guide those working within the framework of the legislation in interpreting its requirements and the suggestion was supported by majority of those consulted. However, the Law Commission concluded that the concept was too imprecise to be expressed as a statutory principle.[79]

Dignity makes several appearances in the NHS Constitution, which was recently amended following the report on the widely publicised and very serious failings in hospital care in Mid-Staffordshire.[80] It sets out seven key principles which are stated to guide the NHS in all it does, a number of values which are said to underpin the principles and a set of rights and responsibilities for both patients and staff. The constitution does not create any new legal rights.[81] Dignity features as a principle, a value and a right. Principle 3, 'Excellence and Professionalism' states that 'respect, dignity, compassion and care should be at the core of how patients and staff are treated.'[82] Dignity also features as one of the core sets of values – 'Dignity and Respect' - which underpin these principles. Thus the constitution states 'we value every person – whether patient, their families or carers, or staff – as an individual,

[77] Including Department of Health (2015) *The NHS Constitution: the NHS belongs to us all* (Department of Health, London); Department of Health (2001) *National Service Framework for Older People* (Department of Health, London)
[78] For example, Care Quality Commission (2012) *Time to care: dignity and nutrition in NHS hospitals* (Care Quality Commission, Newcastle on Tyne); The Mid-Staffordshire NHS Foundation Trust Enquiry (2013) *Report of the Mid-Staffordshire NHS Foundation Trust Enquiry: Executive Summary* (The Stationary Office, London); Parliamentary and Health Service Ombudsman (2011) *Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people* (The Stationary Office, London); Vizard, P. and Burchardt, T. (2015) *Older people's experiences of dignity and nutrition during hospital stays* (LSE, Centre for Analysis of Social Exclusion, CASE report 91) available at http://sticerd.lse.ac.uk/case/_new/research/equality/age_dignity_and_nutrition/default.asp
[79] Law Commission (2011) *Adult Social Care* (LAW COM No 326)
[80] NHS Constitution, note 77, above. See The Mid-Staffordshire NHS Foundation Trust Enquiry (2013), note 81, above.
[81] Department of Health (2015) *The Handbook to the NHS Constitution* (Department of Health, London).
[82] NHS Constitution, note 77 above, at p. 3.

respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits.'[83] Finally, there is an explicit right for patients 'to be treated with dignity and respect, in accordance with your human rights' and a corresponding responsibility for staff to do so.[84] Interestingly perhaps, dignity does not feature in the enumeration of the first principle, which covers non-discrimination, equality and inclusiveness nor as part of the values or rights which deal with non-discrimination, equality and resource allocation. There is no discussion in the document of what dignity means although the NHS Constitution Handbook notes that 'compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the NHS extends beyond providing clinical care and includes alleviating pain, distress and making people feel valued and that their concerns are important.'[85]

Similarly dignity features prominently in the National Service Framework for Older People ('NSF'), a strategy document published by the Department of Health in 2001 which aimed to promote high quality care for older people. It notes that the need for a specific framework for older people 'was triggered by concerns about widespread infringement of dignity and unfair discrimination in older people's access to care. This NSF therefore leads with plans to tackle age discrimination and to ensure that older people are treated with respect, according to their individual needs.'[86] Here, then, and unlike the NHS Constitution, there is an explicit link between discrimination and dignity. Dignity also features in the aspects of the NSF relating in particular to privacy, 'person centred care' enabling older people to maintain independence and end of life care. The Framework was updated in 2006 and identified dignity in care as one of the key priorities for its second phase. In the same year the Department of Health launched a 'Dignity in Care' campaign to improve care for patients of all ages and aiming to set up a network of 'dignity champions' to share and promote best practice in relation to dignity in care.[87]

[83] ibid. p.5.
[84] ibid. p.8.
[85] Department of Health (2015) note 81, above, at p. 14.
[86] Note 77, above, at p.12.
[87] See final report on the campaign at Department of Health (2009) *Final Report on the Review of the Department of Health Dignity in Care Campaign* available at www.dignityincare.org.uk (accessed October 2015).

A number of medical professional and regulatory bodies include dignity as a core value in their guidance.[88] As Foster notes, however, many of these documents fail to define dignity adequately or at all. At best they tend to illustrate dignity with examples of dignified or undignified care but fall short of providing a more comprehensive definition. One notable exception is the Royal College of Nursing who have defined dignity as follows: 'Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat people with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals…When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves.'[89]

Dignity in the empirical literature

As well as dignity featuring in the policy debate on patient care in general and care for older people in particular, there has been academic interest in understanding what dignity means to those involved in giving and receiving care.[90] This has looked at wider health and social care settings including residential care[91] and has included consideration of dignity in particular contexts such as dementia care[92] and end of life care.[93] Much of the research has identified a number of different, related, aspects to dignity. Thus, for example Pleschberger, in a study of the views of nursing home residents on dignity and dying, distinguishes between aspects of dignity which are interpersonal and 'contain those elements which are grounded in personal

[88] E.g. General Medical Council (2013) *Good Medical Practice* (available at http://www.gmc-uk.org/guidance/good_medical_practice.asp, accessed October 2015) states 'You must treat your patients as individuals and respect their dignity and privacy' (at para. 47); The General Dental Council (2013) *Standards for the Dental Team* (General Dental Council, London) states that 'You must treat every patient with dignity and respect at all times' (at 1.2); The Care Quality Commission's *Fundamental Standards* include the requirement that 'You be treated with dignity and respect at all times while you're receiving care or treatment' as one of its five fundamental standards below which care must not fall (http://www.cqc.org.uk/content/fundamental-standards accessed October 2015)

[89] Royal College of Nursing (2008) *Defending Dignity: Challenges and Opportunities for Nursing* (RCN, London).

[90] See for example Nordenfelt, L. (2003) 'Dignity and the care of the elderly' *Medicine, Health Care and Philosophy* 6 103-110; (2004) 'The Varieties of Dignity' *Health Care Analysis* 12 69-81; (2009) *Dignity in Care for Older People* (Blackwell, Oxford); Edgar A. (2004) 'A response to Nordenfelt's 'The Varieties of Dignity'' *Health Care Analysis* 12 83-89; Wainwright, P. and Gallagher, A. (2008) 'On different types of dignity in nursing care: a critique of Nordenfelt' *Nursing Philosophy* 9 46-54; Woolhead, G. et al. (2004) 'Dignity in older age: what do older people in the United Kingdom think?' Vol.33 No.2 *Age and Ageing* 165.

[91] Pleschberger, S. (2007) 'Dignity and the challenge of dying in nursing homes: the residents' views' *Age and Ageing* 36,197; Franklin, L. et al (2006) 'Views on Dignity of Elderly Nursing Home Residents' *Nursing Ethics* 2006 13(2); Hall, S. et al (2009) 'Living and dying with dignity: a qualitative study of the view of people in nursing homes' 38 *Age and Ageing* 411.

[92] Ohlander, M. (2009) 'Dignity and Dementia: An Analysis of Dignity of Identity and Dignity Work in a Small Residential Home' and Hellstrom, I. (2009) 'Dignity and Older Spouses with Dementia' both in Nordenfelt, L. (ed) *Dignity in Care for Older People* (Blackwell, Oxford)

[93] Ternestsdt, B-M. (2009) 'A Dignified Death and Identity-Promoting Care' in Nordenfelt, L. (ed) *Dignity in Care for Older People* (Blackwell, Oxford)

beliefs and in aspects of the body' and aspects of dignity which are relational and depend upon recognition and appropriate treatment by others.[94] Similarly Nordenfelt argues that there are a number of different, related, aspects to dignity (human dignity, dignity of identity, dignity of merit and dignity of moral stature) not all of which will prove equally relevant in different contexts. Two of these aspects, human dignity and, particularly, dignity of identity are most helpful in relation to understanding the needs of those in receipt of care.[95]

A recent large scale empirical research project, Dignity and Older Europeans, funded by the European Commission, set out to explore the meanings of dignity to those involved in the provision and receipt of care, including older people and professionals engaged in providing care for older people, using the theoretical framework developed by Nordenfelt as a starting point.[96] Again, the results suggested that dignity was seen as a multi-faceted concept involving several related aspects. Tadd notes that it was dignity of identity that was reflected most in older people's discussions of dignity and that this was evident in a number of different themes which emerged from the research. Themes felt to relate to dignity of identity included: fear of becoming a burden; the respect of others and its impact on self-respect; a sense of invisibility and being ignored; and humiliation (including in relation to bodily privacy and toileting practices). A failure of appropriate communication by health professionals was highlighted as very important to feelings of indignity, in particular where individuals felt that they had been ignored, excluded from decision making or treated as objects. Tadd reports that all participants had highlighted that ageist stereotypes had a particularly negative impact on this form of dignity, noting that these negative stereotypes 'inhibited acknowledgement of older people's diversity, their potential and consequences.'[97] In addition to these themes, other important aspect of dignity identified by participants in the study were choice, control and equality (categorised by the authors as falling under 'Human Dignity' within Nordenfelt's framework). In particular, it is reported, participants in the study wanted to exercise choice about care alternatives. Interestingly, many participants claimed that the 'right to choose' was more important that the appropriateness of the choice.[98]

[94] Pleschberger, note 91, above, p. 199.
[95] Nordenfelt (2009) note 90, above.
[96] European Commission, DG Research, *Dignity and Older Europeans Project*, (project reference QLG6-CT-2001-00888).
[97] Tadd, W. and Calnan, M. (2009) 'Caring for Older People: Why Dignity Matters – the European Experience' in Nordenfelt, L. (Ed.) *Dignity in Care for Older People* (Blackwell, Oxford)
[98] Dignity in these studies is not linked to questions about availability of particular treatment options but of choices between available options.

Several of these aspects of dignity are familiar from the survey of the relevant case law above. These include the importance of patient involvement in decision making (*Tracey, Montgomery, McDonald*), the avoidance of humiliation (*Bland, McDonald*) and the need to preserve strongly held feelings of personal identity. There are few UK cases concerning dignity in 'care' (although *McDonald,* above, is a good example of a case which may fit within this broad category.) Several of the cases that do touch on dignity in care involve issues of disability discrimination and equality and as such are dealt with in chapter seven.

Conclusion

What perhaps emerges most strongly from the cases considered above is that there are some health states which are so distressing, debilitating, humiliating or undermining of identity that they are incompatible with human dignity. Courts have not, however, found there to be a positive right to treatment to relieve individuals from these conditions. Less clear is the relationship between autonomy and dignity. They are normally treated as separate but closely related interests and, again, while dignity has been held to found a right to be informed and consulted, it remains the case that patients have no right to insist on any particular course of intervention. Autonomy based accounts of dignity are perhaps more evident in the empirical research, which stressed the importance both of control in its own right, and of the recognition of continued independence and autonomy by medical practitioners and carers.

CHAPTER SEVEN: DIGNITY AND EQUALITY LAW

Introduction

It has been long agreed by most legal theorists with an interest in discrimination that the principle of equal treatment, without more, is an inadequate normative basis for the body of laws which are generally classified as making up 'discrimination law.' Among other things, the principle of equal treatment fails to provide answers to many of the questions to which existing legal frameworks give rise. Thus, for example, it cannot explain when individuals or situations are relevantly alike so as to require equal treatment; it does not explain why it is unacceptable to treat people equally badly; and it cannot explain which grounds or personal characteristics should be subject to the protection of the law.[1]

In response to these, and other, difficulties, it is usually suggested that different principles are needed to generate a richer, substantive, notion of equality, or to stand alongside or in place of equality in providing a normative underpinning for the law. These arguments tend to fall into two camps. Some theorists argue, on the one hand, that there must be another principle which serves as the normative basis for the law and which can unite and explain its various, often rather disparate, provisions. Candidates for principles from which a coherent theory of discrimination law can be developed have included social exclusion,[2] liberty[3] and dignity.[4] Other theorists have been sceptical of this approach, arguing that that there is no single principle underpinning discrimination law but rather a cluster of related principles or interests which, together or separately, can explain the existing law and can guide the courts in resolving issues which arise.[5] Again, dignity often appears as one of these principles or interests.[6]

[1] See, for example, Fredman, S. (2011) *Discrimination Law* (OUP, Oxford) for a useful summary of the difficulties of equal treatment approaches.
[2] Collins, H. (2003) 'Discrimination, Equality and Social Inclusion' 66 *Modern Law Review* 16.
[3] Khaitan, T. (2015) *A Theory of Discrimination Law* (OUP, Oxford).
[4] Reaume, D. (2003) 'Dignity and Discrimination' 63 *Louisiana Law Review* 645 and (2013) 'Dignity, Equality and Comparison' in Hellman, D. and Moreau, S.(ed.'s) (2013) *Philosophical Foundations of Discrimination Law* (OUP, Oxford).
[5] See, for example, Rutherglen, G. (2013) 'Concrete or Abstract Conceptions of Discrimination' in Hellman, D. and Moreau, S. (2013), note 4 above; O'Cinneide, C. (2006) 'Fumbling Towards Coherence: The Slow Evolution of Equality and Anti-Discrimination Law in Britain' *Northern Ireland Law Quarterly* 57.
[6] Fredman, S. (2011) note 1 above.

This chapter will explore briefly some of the arguments for giving dignity a role as either the, or one of the, principles underlying discrimination law and some of the general difficulties with, and criticisms of, using dignity in this way. It will be seen that, inevitably, the success of dignity in this role depends on the meaning it is given. The chapter will then turn to explore the various meanings of dignity evident in the jurisprudence and in statute. The focus will be on the law in the UK, EU and under the ECHR but the chapter will also consider other jurisdictions and look in some depth at Canada where dignity has played a very significant role in the evolution of the relevant law.

The role of dignity in anti-discrimination law

*Dignity as **the** normative basis for anti-discrimination law*

In a number of jurisdictions, most notably Canada and South Africa,[7] dignity has been identified by the Courts as the fundamental aim of constitutional equality guarantees.[8] Thus, in *Law v Canada*[9] in 1999, the Supreme Court of Canada held that the protection of dignity as the purpose of s.15(1) of Canada's Charter of Rights. S.15(1) provides that 'Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.' In *Law,* Iacobucci, J. explained that the aim of the provision was 'to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration.'[10] In determining whether a challenged law was discriminatory the Court was therefore to ask itself whether it imposed a burden or withheld a benefit from the claimant 'in a manner which reflects the stereotypical application of presumed group or personal characteristics, or…otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of

[7] *Harksen v Lane NO* [1998] (1) SA 300 (CC)
[8] Dupre notes that dignity was also a central feature of constitutional transition in a number of Eastern European States, and particularly Hungary, following the fall of the communist regimes, where there was a need to find notion of equality which moved away from ideas of redistribution. Dupre, C. (2013) 'Human Dignity in Europe: A Foundational Constitutional Principle' *European Public Law* 19(2) 319-340. See also discussion of this point in McCrudden, C. (2008) 'Human Dignity and Judicial Interpretation of Human Rights' *European Journal of International Law* 19(4), 655-724.
[9] [1999] 1 SCR 497
[10] Ibid.at 56

recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration.' The Constitutional Court of South Africa has developed a similar approach to the interpretation of s.9 of the South African Constitution which enshrines the right to Equality.[11]

A number of commentators, most notably Denise Reaume, have approved this broad approach of making dignity the focus of enquiry in interpreting the Equality guarantee, though recognising that in the hands of the courts it has not always lived up to its potential. [12] While noting the difficulties with providing an adequate definition of dignity, she argues that 'although a great deal of work needs to be done in fleshing out a concept of dignity capable of filling this role, the Court is on the right track in latching onto dignity as the substantive concept informing equality rights.'[13] However, in general, critics of this use of dignity as the central focus of inquiry have outnumbered its supporters and now include the Canadian Supreme Court itself.[14] There are a number of strands of criticism. First, and familiar from the preceding two chapters, is the charge that dignity is too vague a concept to be useful. As L'Heureux-Dubé J acknowledged in *Egan v Canada*, 'Dignity [is] a notoriously elusive concept . . . it is clear that [it] cannot, by itself, bear the weight of s.15's task on its shoulders. It needs precision and elaboration.'[15] Further, it has been suggested that this lack of clear definition means that dignity is a 'shell concept' which can then be used by courts to reflect majoritarian conceptions of what dignity entails which provide a 'reflexive assertion of accepted social norms'[16] and do not challenge the status quo.[17]

Second, and a concern expressed by the Supreme Court of Canada, is that dignity had become an additional hurdle for claimants attempting to demonstrate unfair discrimination, at least in the way the concept had been deployed by the court. In particular, the use of four 'contextual factors' outlined by Iacobucci in *Law*, while intended as a set of non-exhaustive guidelines to help detect violations of dignity, had instead been treated as a legal test for

[11] *Harksen v Lane* note 7, above and see discussion in McConnachie, C. (2014) 'Human Dignity, 'Unfair Discrimination' and Guidance' *Oxford Journal of Legal Studies* 34(3) 609-629.
[12] Reaume (2003) and (2013) note 4 above; Moon, G. and Allen, R. (2006) 'Dignity discourse in discrimination law: a better route to equality?' *European Human Rights Law Review* 6, 610-649.
[13] Reaume (2003), ibid, p.646.
[14] In *R v Kapp* [2008] 2 SCR 483
[15] *Egan* v *Canada*[1995] 2 SCR 513 at 545
[16] O'Connell, R. (2008) 'The role of dignity in equality law: Lessons from Canada and South Africa' 6(2) *International Journal of Constitutional Law* 267 – 286 at 283.
[17] Grabham, E. (2002) '*Law v Canada*: New Directions for Equality Under the Canadian Charter?' *Oxford Journal of Legal Studies* 22(4) 641

claimants to pass.[18] As the Court noted in *Kapp* 'several difficulties have arisen from the attempt to employ human dignity as a legal test….As critics have pointed out, human dignity is an abstract and subjective notion that, even with the guidance of the four contextual factors, cannot only become confusing and difficult to apply; it has also proven to be an additional burden on equality claimants, rather than the philosophical enhancement it was intended to be.' [19]

Third, there is concern that focus on dignity reduces the scope for the judiciary to recognise other harms. In the Canadian context it is argued that the rigid application in practice of the four contextual factors has meant that not all of the potential wrongs associated with unequal treatment are identified. Moreau, for example, argues that the problem with the role given to dignity, at least in the way dignity has been construed by the courts, is that it treats one wrong – violation of dignity - as a complete account of what is wrong with discrimination.[20] She identifies a number of other 'wrongs' associated with unequal treatment which dignity alone cannot explain; these include use of stereotype (which need not be a negative one, although the harm which results from the use of a stereotype which is negative may be different from or greater than the harm which results from a value neutral or positive one), prejudice, oppression and denial of basic goods. The approach taken by the Canadian courts in assessing and balancing the contextual factors has, she argues, too often resulted in a failure to identify the presence of one or more of these wrongs in a particular factual context. Similar points are made by Fredman and by Fudge, again in the Canadian context, who argue that the focus on dignity, combined with the court's view as to the limitations of its institutional role, have hampered the redistributive potential of the s.15 equality guarantee because it has allowed the court to interpret the equality guarantee as prohibiting status based rather than socio-economic inequalities.[21]

Of course these criticisms are often made in relation to a particular conception of dignity. Much of the criticism of the dignity approach in the Canadian context has noted that the

[18] See discussion in Fudge, J. (2007) 'Substantive Equality, the Supreme Court of Canada, and the Limits to Redistribution' 23 *South African Journal on Human Rights* 235-252, and below, for more detail.
[19] Note 14, above, at 22.
[20] Moreau, S. (2004) 'The Wrongs of Unequal Treatment' *University of Toronto Law Journal* 57(2) 291-326.
[21] Fudge, note 18, above. See also Fredman, S. (2007) 'Redistribution and Recognition: Reconciling Inequalities.' 23 *South African Journal on Human Rights* 214-234. Lucy Vickers argues that the UK public sector equality duty, at least as it applies in relation to religion or belief, should be based on a concept of equality based on disadvantage, rather than dignity, due to the inability of equality as dignity or recognition to properly accommodate the diverse range of individual beliefs within broad religious groupings in (2011) 'Promoting equality or fostering resentment? The public sector equality duty and religion and belief.' *Legal Studies* 31(1) 135-158.

meaning given to dignity by the Canadian court has been very narrow and is therefore unable to explain the wider range of wrongs which the Equality Guarantee should serve to correct. The potential meanings of dignity in the equality context will be explored in more depth below, including in relation to those evident in the Canadian jurisprudence. However, it is worth noting here that - as should be apparent from chapter five – there is certainly scope to define dignity in a way that recognises a broader range of interests as dignity interests (including socio-economic interests requiring redistribution). Reaume, one of the foremost proponents of dignity as the normative basis for discrimination law, has attempted to construct an account of dignity which does just this. Her contribution is discussed below.

*Dignity as **a** normative basis for discrimination law*

An alternative to striving to find one principle to underpin and explain anti-discrimination norms, whether that be dignity or some other principle, is to acknowledge that there is no one principle which can do all the work. On this view, as O'Cinneide explains, equality and anti-discrimination norms are seen as 'a complex construct of different elements.'[22] Each element may serve to explain some of the harms which arise from particular types of unfair treatment and thus some of the aims of the law but no element can provide a complete explanation on its own. Fredman advances a conception of substantive equality which incorporates several different aspects, including dignity. She argues that substantive equality should be seen as a multi-dimensional concept pursuing (at least) four overlapping aims: a redistributive dimension which seeks to remedy disadvantage attached to particular groups); a recognition dimension which aims to promote dignity and respect for all and to ensure in particular that individuals are not humiliated or degraded by status based prejudice; a transformative dimension which (in conjunction with the recognition dimension) is focussed on the accommodation of difference and on effecting the structural changes necessary to ensure that barriers faced by particular groups are removed; and a participative dimension which relates to the goals of ensuring social inclusion and political voice for all. Thus dignity has a part to play but does not serve as an overarching principle.[23] For Fredman, the recognition dimension of dignity requires that individuals not be humiliated or degraded through status-based prejudice.

[22] O'Cinneide, C. note 5, above, at 61-62.
[23] See also Hepple who argues that dignity is one of seven meanings of equality as reflected in the Equality Act 2010 but cannot serve as a single unifying principle: Hepple, B. (2014) *Equality: The Legal Framework* (Hart, Oxford).

Moreau argues that while the Kantian notion of inherent worth may require that all humans be treated with equal respect and concern, this particular conception of dignity cannot tell us what kinds of behaviour fail to demonstrate equal respect and concern. Discrimination involves several wrongs, all of which may fail to show equal concern and respect, but each is based on a different substantive conception of what makes unequal treatment wrong. No single type of wrong is present in all cases of unfair unequal treatment. The four wrongs identified (which, she admits, may not be exhaustive) are stereotyping (which, for Moreau, need not involve any negative connotations), perpetuating oppressive power relations, exclusion from access to basic goods and diminishing feelings of self-worth. Only in relation to the last of these, Moreau argues, does dignity do any explanatory work[24] and this is a different and narrower conception of dignity than the overarching Kantian notion identified above. This narrow conception of dignity relates to subjective feelings of self-worth and self-respect. Given that objectively fair treatment may nonetheless diminish subjective feelings of self-worth in some, Moreau notes that the existence of this harm alone is not sufficient to signal the existence of unfair treatment. Instead, where treatment harms self-respect in addition to creating one of the other harms identified the harm to self -respect amounts to an additional wrong.[25]

Dignity and the law

While it has played a very significant role in the evolution of anti-discrimination law in other jurisdictions, dignity – or at least explicit references to the concept – has not played a major role in non-discrimination statute or case law in the UK or EU or in the jurisprudence of the ECtHR. While dignity forms part of the statutory test for harassment in the Equality Act 2010, the proposal that the Act should contain a set of interpretive principles, including dignity, was rejected by the Government.[26] And while the European Charter, does refer once to dignity in the context of the Equality chapter of the Charter, Article 25 providing that 'The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life,' the 'Dignity' chapter of the

[24] Moreau does also note that stereotyping which involves negative connotations necessarily involves treating people as of less worth and is therefore a breach of the requirement to treat others with equal respect and concern. However the essential wrong in stereotyping, she argues, whether or not negative connotations are involved is in the restriction on the autonomy this involves for the individual concerned. Note 20, above.
[25] Moreau, note 20, above.
[26] Hepple, note 23, above.

Charter is presented as something entirely separate from the 'Equality' chapter.[27] Nonetheless, even though it is not a consistent feature, dignity has from time to time played a significant role in the equality jurisprudence of the courts. The following section explores the way dignity has featured in the legal analysis of a number of difficult issues arising in discrimination law. It will also look more closely at the meanings of dignity in the Canadian jurisprudence.

Dignity and the grounds of discrimination

One of the potential uses of dignity, advocated by its adherents, is in defining the scope of protection of anti-discrimination and equality provisions. In particular, it is argued, dignity is helpful in determining which groups and characteristics should be the subject of protection.[28] This is less of an issue for courts under the UK Equality Act and the EU anti-discrimination Directives, which operate with a 'closed' list of protected characteristics. However, in other jurisdictions, and under Article 14 of the European Convention on Human Rights, where statutory and constitutional anti-discrimination provisions do not specify a finite list of protected groups, courts are left with the task of determining the scope of protection and thus are in need of a principle or principles to help them do so. Dignity has served this purpose in a number of jurisdictions, including Canada and South Africa.[29] Thus, for example, the South African Constitutional Court has held that, under the Constitution, 'there will be discrimination on an unspecified ground if it is based on attributes or characteristics which have the potential to impair the fundamental dignity of persons as human beings, or to affect them adversely in a comparably serious manner.'[30]

Despite working with a complete list of protected characteristics, the CJEU has on a few occasions been required to consider whether an existing protected characteristic can be interpreted so as to stretch to cover a new situation. Dignity has sometimes, but not always, featured in the legal analysis of the court in these situations.[31] In *P and S v Cornwall* the court addressed the question of whether discrimination on grounds of gender reassignment

[27] European Charter of Fundamental Rights
[28] Moon and Allen, note 12, above; Reaume (2003), note 4, above.
[29] See, for example, *Egan* v *Canada*, note 15, above; *Corbiere* v *Canada (Minister of Indian and Northern Affairs)* [1999] 2 SCR 203; *Harksen v Lane*, note 7, above. See also discussion in Fredman (2011) note 1, above.
[30] *Harksen v Lane* note 7, above, at 46.
[31] Dignity did not feature, for example, in the Court's recent analysis of whether obesity is a protected characteristic in *Fag og Arbejde (FOA) v Kommunernes Landsforening (KL)* (C-354/13) [2015] 2 CMLR 19.

(now a characteristic specifically protected under the recast equal treatment directive) was a form of prohibited sex discrimination. It concluded that it was because

> 'such discrimination is based, essentially if not exclusively, on the sex of the person concerned. Where a person is dismissed on the ground that he or she intends to undergo, or has undergone, gender reassignment, he or she is treated unfavourably by comparison with persons of the sex to which he or she was deemed to belong before undergoing gender reassignment. To tolerate such discrimination would be tantamount, as regards such a person, to a failure to respect the dignity and freedom to which he or she is entitled, and which the Court has a duty to safeguard.'[32]

While this establishes respect for dignity as a central aim of EU Discrimination Law, the court offers little insight into what dignity means or what safeguarding dignity may require. A more extensive account was set out in the Opinion of Advocate General Maduro in *Coleman*, a case which raised the issue of whether the Framework Directive prohibited discrimination against those who associate with people with disabilities.[33] In this case the claimant argued she had been treated less favourably by her employer because of the disability of her son. At the time the Disability Discrimination Act in the UK prohibited disability discrimination only against those who were themselves disabled. Advocate General Maduro, whose opinion was followed by the Court (though the Court did not discuss dignity) expanded on what was meant by dignity. He begins by 'recalling' that the values underlying equality are human dignity and personal autonomy[34] and identifies the protection of the autonomy and dignity of those belonging to suspect classification as the aim of Article 19 (then Article 13) TFEU.[35] He then defines dignity and autonomy as follows:

> 'At its bare minimum, human dignity entails the recognition of the equal worth of every individual. One's life is valuable by virtue of the mere fact that one is human, and no life is more or less valuable than another...Therefore, individuals and political institutions must not act in a way that denies the intrinsic importance of every human life. A relevant, but different, value is that of personal autonomy. It dictates that individuals should be able to design and conduct the course of their lives through a succession of choices among different valuable options. The exercise of autonomy presupposes that people are given a range of valuable options

[32] *P v S and Cornwall CC* [1996] 2 CMLR 247 at 263.
[33] *Coleman v Attridge Law (A Firm)* (C-303/06) [2008] 3 CMLR 27, Opinion of Advocate General Poiares Maduro delivered on 31 January 2008
[34] ibid.at para. 8.
[35] ibid at para. 10. Article 19(1) of the Treaty on the Functioning of the European Union (TFEU) provides that '[w]ithout prejudice to the other provisions of this Treaty and within the limits of the powers conferred by it upon the Community, the Council, acting unanimously on a proposal from the Commission and after consulting the European Parliament, may take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.'

> from which to choose. When we act as autonomous agents making decisions about the way we want our life to develop our "personal integrity and sense of dignity and self-respect are made concrete"… The most obvious way in which such a person's dignity and autonomy may be affected is when one is directly targeted because one has a suspect characteristic. Treating someone less well on the basis of reasons such as religious belief, age, disability and sexual orientation undermines this special and unique value that people have by virtue of being human. Recognising the equal worth of every human being means that we should be blind to considerations of this type when we impose a burden on someone or deprive someone of a benefit. [36]

Here, then, dignity is explicitly tied to the moral imperative of treating each other as equally valuable. It is an objective standard. Certain types of treatment just will violate dignity because they fail to treat another individual as equally valuable. This echoes the explanation given by Hale in *Ghaidan* in relation to Article 14 and Article 8 of the ECHR: 'Democracy is founded on the principle that each individual has equal value. Treating some as automatically having less value than others not only causes pain and distress to that person but also violates his or her dignity as a human being. The essence of the Convention, as has often been said, is respect for human dignity and human freedom: see Pretty v United Kingdom (2002) 35 EHRR 1, 37, para 65.'[37] Here the feelings of the 'victim' of the discriminatory act are a matter of concern but are not determinative of whether dignity has been violated. They amount to an additional harm. However, in describing the relationship between dignity and autonomy as distinct but closely related values, the Advocate General also suggests a second, subjective, meaning of dignity. His comments suggest that autonomy may be necessary as a means of realising subjective feelings of dignity and self-respect. He concluded that discrimination by association should be prohibited not only because it harms the individual on the immediate receiving end of the treatment but, crucially, because it undermines the dignity and autonomy of the person with the protected characteristic.

Harassment

The provisions prohibiting harassment in the Equality Act and the EU Equality Directives provide a rare example of an explicit statutory right to dignity. Thus s.26 of the Equality Act provides:

(1)A person (A) harasses another (B) if—

[36] Ibid, para.'s 9 and 10.
[37] *Ghaidan v Godin Mendoza* [2004] UKHL 30 at 132.

(a)A engages in unwanted conduct related to a relevant protected characteristic, and

(b)the conduct has the purpose or effect of—

(i)violating B's dignity, or

(ii)creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

Before the evolution of the current statutory definition of discriminatory harassment, victims of sexual or other harassment had had to show that their treatment was less favourable treatment on grounds of their sex or race or other protected characteristic. Employers, and others, were thus able to escape liability on the basis that those without the relevant characteristic were treated equally badly.[38] Provided, for example, that both men and women were, or would have been, treated equally badly there could be no discrimination on grounds of sex even where the means of harassment involved unwanted sexual conduct or the use of derogatory sex or gender based language. Over time, however, it was accepted that the use of personal characteristics as a means of harassment was a breach of anti-discrimination norms even where there was consistency of treatment. In reaching this conclusion a different principle – dignity –was needed to explain the wrong done by the discrimination. As Fredman notes, 'in the field of harassment, the stress on dignity has facilitated a transformation of direct discrimination from a principle based entirely on consistency, to one embedded in substantive values.'[39]

What exactly dignity means in the context of s.26 is unclear, however. Its meaning, in relation to statutory harassment, has not been considered by either the UK courts or by the CJEU.[40] It seems clearly linked to notions of self-respect and self-worth. However it is unclear exactly what it is that the prohibition on violating dignity in s.26(1)(b)(i) adds to the prohibition on creating an 'intimidating, hostile, degrading, humiliating or offensive environment' in S26(1)(b)(ii). It is clear from the previous chapters that treatment which is, for example, degrading and humiliating, is normally argued to be wrong precisely because it

[38] *Stewart v Cleveland Guest (Engineering) Ltd* [1996] ICR 535; *Pearce v Mayfield Secondary School Governing Body* [2001] EWCA Civ 1347.
[39] Fredman (2011), note 1, above p. 228.
[40] See discussion in Numhauser-Henning, A. and Laulom, S. (2012) *Harassment related to Sex and Sexual Harassment Law in 33 European Countries: Discrimination versus Dignity* (European Commission).

is a violation of dignity.[41] It is not obvious what kind of treatment may be found by the courts to satisfy the dignity limb of the test but not the 'intimidating…' limb, or indeed vice versa.[42]

It is worth noting that the Equality Act requires courts to take a mixed subjective/objective approach to the question of whether the dignity of the claimant has been violated (or indeed whether an intimidating, hostile, degrading, humiliating or offensive environment has been created.) Thus, in judging whether the treatment has had the effect of violating dignity the court is required to consider the perception of the claimant, the other circumstances, and whether it was reasonable for the treatment to have that effect. Thus, whatever dignity is, the analysis of it incorporates both subjective and objective views as to whether it has been violated. It may be, as Vickers has argued, that the lack of definition of dignity here will allow the Courts to be more sensitive to context and in particular in distinguishing between the different types of offence which may be caused by the use of, for example, racist or sexist language on the one hand and strongly expressed disagreement with religious teaching on the other.[43] The courts have yet to explore this avenue, however. Interestingly it is generally agreed by those considering the implementation of the EU harassment provisions in Germany that the meaning of dignity in the context of the German General Equal Treatment Act, implementing the relevant EU provisions, is different from the use of dignity in the German Constitution, discussed in Chapter 5. In the context of the harassment provisions of the Equal Treatment Act, dignity is simply conceptualised as a measure of the seriousness of the harassment.[44]

Dignity, Disability and Difference

One problem for discrimination law is to explain when it is that different, rather than equal, treatment may be permitted or required in order to recognise and accommodate differences between protected groups. Again, dignity plays a significant role in the debate on the issue.[45] Dignity is often conceptualised as requiring the recognition of the differences and needs of

[41] Although see Statman, D. (2000) 'Humiliation, dignity and self-respect' *Philosophical Psychology* 13(4) 523-540, who argues that associating humiliation too closely with human dignity risks making the concept of humiliation too philosophical and too detached from psychological research.
[42] Interestingly, the wording of the test for harassment in the relevant EU Directives is different, requiring both limbs of the test to be satisfied, rather than only one. See Framework Directive (Council Directive 2000/78/EC), Race Directive (Council Directive 2000/43/EC) and Recast Equal Treatment Directive (Council Directive 2006/54/EC) and see discussion in Hepple, B. (2014) *Equality: The Legal Framework* (Hart, Oxford). The difficulty with identifying what may constitute an infringement of dignity here remains, however.
[43] Vickers, L. (2006) 'Is All Harassment Equal? The Case of Religious Harassment' *Cambridge Law Journal* 65(3) 579-605.
[44] Numhauser–Henning and Laulom, note 40, above.
[45] Moon and Allen, note 12, above; Reaume (2003) note 4, above.

groups. As was seen in Chapter 5, while for some 'dignity as recognition' is principally a matter of recognising the particularity of each individual and avoiding assumptions about the identity of individuals as a result of their membership of particular groups, for others it also involves a recognition of the need for different treatment which exists because of a characteristic shared by members of a protected group.[46] Indeed concern is sometimes raised about the potential tension between recognising individuality and recognising the needs of particular groups – and as a result about the limitations of dignity as recognition. Too much emphasis on group characteristics ignores the differences and multiple identities of those within the group. Too much emphasis on the individual and insufficient attention is paid to the wider context of the historical, structural and institutional barriers that exist for certain groups.[47]

The need for different treatment in order to achieve substantive equality is perhaps most obvious in relation to disability. The recognition of the need to accommodate difference in relation to those with disabilities is enshrined in UK and EU Equality law in the duty to make reasonable adjustments. It was recognised by the ECtHR in *Price v United Kingdom* where the Court held that treatment which would not normally amount to a breach of Article 3 of the Convention, prohibiting inhuman and degrading treatment, may amount to a breach where the individual is severely disabled: 'The applicant's disabilities are not hidden or easily overlooked. It requires no special qualification, only a minimum of ordinary human empathy, to appreciate her situation and to understand that to avoid unnecessary hardship — that is, hardship not implicit in the imprisonment of an able-bodied person — she has to be treated differently from other people because her situation is significantly different.' [48]

In *East Sussex*, which considered whether the provision of care by the Local Authority to two severely disabled adults was in breach of Articles 3 and 8 of the ECHR, Munby LJ made an explicit link between the need for different treatment or enhanced protection for those with disabilities and human dignity.[49] *East Sussex* involved a claim by two young adults with serious physical and learning disabilities (via their litigation friend) and their parents, that the Local Authority's refusal to require their carers to engage in manual lifting rather than mechanical lifting (by hoist) when providing extensive care for them, was contrary to their

[46] For Fredman, for example, it is a different dimension of equality, the transformative dimension, and not the recognition dimension, that requires us to respect and accommodate difference: Fredman (2011) note 1, above.
[47] See Grabham, note 17 above and discussion in McColgan, A. (2014) *Discrimination, Equality and the Law* (Hart, Oxford).
[48] [2002] 34 EHRR 53, Opinion of Judge Greve, at 1297.
[49] *R (A, B, X and Y) v East Sussex CC and the Disability Rights Commission (No 2)* [2003] EWHC 167 (Admin)

rights under the Convention. Munby developed the discussion of dignity at some length in his judgment. There are a number of interesting features to his approach.

First, and following *Price*, he held that enhanced protection of Article 8 rights is needed when the dignity of highly vulnerable or dependent individuals is at stake: 'In order to avoid discriminating against the disabled…one may, as Judge Greve recognised, need to treat the disabled differently precisely because their situation is significantly different from that of the able-bodied. Moreover, the positive obligation for the state to secure their essential Human Dignity calls for human empathy and humane concern as society…seeks to try to ameliorate and compensate for the disabilities faced by persons in A and B's situation.'[50] Protection of dignity, he argues, is an essential component of the protection of psychological and physical integrity which are protected by Article 8.

Second, Munby noted, the kind of treatment that may be required to satisfy the requirement to 'secure' dignity is dependent on context, which includes both time and place. What may have passed as dignified treatment many years ago may no longer do so. Community conceptions of what dignity looks like may change over time to reflect changing social norms and may reflect different cultural contexts. Here, he notes, 'changes in social standards demand better provision for the disabled if their human dignity is not to be impaired.'[51] What dignity requires is defined by the community rather than by the individual.

Third, noting that much of the discussion of dignity by counsel in the case had centred around the issue of whether various methods of lifting were more or less undignified for the claimants, Munby suggested that undignified means may sometimes be necessary in order to achieve dignified ends: 'Dignity in the narrow context in which it has been used during much of the argument in this case is in truth part of a much wider concept of dignity, part of a complicated equation including such elusive concepts as, for example, (feelings of) interdependence and access to the world and others.'[52]He noted that while hoisting may be experienced as undignified by claimants and those close to them, it may also be necessary for dignity because 'it can facilitate dignity, comfort, safety and independence. It all depends on the context.'[53] On this view, not every instance of indignity is problematic if dignity is being

[50] ibid at 93.
[51] ibid at 98.
[52] Ibid at 122
[53] Ibid. This bears a strong resemblance to the arguments of the defendant authority In *R (on the application of McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33, discussed in chapter 6, which were

maximised in the end. Dignity may feature in both the 'pros' and 'cons' list of any contested measure and the question is then to work out which answer best supports dignity viewed in its widest sense.

Fourth, Munby argued that the dignity interests of the claimants had to be weighed against other factors. These included, in particular, the dignity interests of those carers engaged by the local authority to care for the claimants which are also protected implicitly by Article 8 and explicitly by Article 31(1) of the EU Charter of Fundamental Rights which provides that 'Every worker has the right to working conditions which respect his or her health, safety and dignity.'

For Munby, then, dignity appears to relate closely to the conditions, physical and psychological, necessary to live a dignified life. Achieving such standards may be harder for an individual with disabilities and so Article 8 imposes a higher degree of protection to require states to act to achieve this, recognising that a life with dignity may require those with disabilities to be afforded different treatment in certain situations. Threats to dignity do not seem to arise from the bare fact of discrimination, when this is characterised as a failure to recognise difference, but from the consequences of that failure for the ability of the individual involved to live a dignified life. There is no suggestion in the argument that, on the facts, the treatment of the applicants was a violation of their dignity because it conveyed that they were less valuable than those without disabilities.[54]

Dignity and Positive Discrimination

A closely related issue is the question of whether and when positive or 'reverse' discrimination or affirmative action, which uses status to grant preferential access to some benefit, is permissible. Again, dignity features in debate on this issue and can appear on both sides of the argument. On the one hand there is a concern that, because reverse discrimination necessarily involves restricting opportunities for individuals for reasons of status rather than merit, it fails to respect the dignity of the excluded individuals in exactly the same way as does pernicious discrimination. This view of dignity is evident is some of the US

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accepted by the court. There the use of incontinence pads was not a violation for dignity, it was asserted, because they facilitated safety and independence.

[54] The need for different treatment of those not similarly situated has been recognised by the Court in relation to Article 14 since *Thlimmenos v Greece* [2001] 31 EHRR 15 where it held (at 44) that 'the right not to be discriminated against in the enjoyment of the rights guaranteed under the Convention is also violated when States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different.' Dignity did not feature in the analysis.

jurisprudence on the issue. Thus, for example, in the US case of *Rice v Cayetano*, which concerned the use of a race based classification to determine access to voting rights for the trustees of the Office of Hawaiian Affairs, Justice Kennedy argued that '[o]ne of the principal reasons race is treated as a forbidden classification is that it demeans the dignity and worth of a person to be judged by ancestry instead of by his or her own merit and essential qualities. An inquiry into ancestral lines is not consistent with respect based on the unique personality each of us possesses, a respect the Constitution itself secures in its concern for persons and citizens.' [55] On this view, then, dignity requires respect for individuality and is infringed by any use of status or group membership for determining access to rights or benefits, no matter what the aim behind the measure.

There are two main dignity-related responses to this charge.[56] One is to say that the use of status to determine access in the context of reverse discrimination measures is not an affront to dignity in the way described by Justice Kennedy because the use of status in these cases does not involve the use of prejudice or stereotype. Where affirmative action measures are used the 'excluded' group is usually the majority or socially or historically advantaged group. For Reaume, for example, it is largely the attribution of negative worth (when viewed in the appropriate historical and social context) which distinguishes uses of status which infringe dignity from those which do not.[57] Dworkin goes a step further, arguing that in relation to certain affirmative action measures, the status in question may sometimes be constitutive of the merit and essential qualities to which Kennedy J was referring. Thus, in the context of the underrepresentation of black doctors in the medical profession in the US, he has argued that 'If a black skin will, as a matter of regrettable fact, enable another doctor to do a different medical job better, then that black skin is by the same token 'merit' as well. That argument may strike some as dangerous; but only because they confuse its conclusion – that black skin may be a socially useful trait in particular circumstances – with the very different and despicable idea that one race may be inherently more worthy than another.'[58]

[55] [2000] 528 US 495.
[56] There is, of course, an extensive literature on reverse discrimination and it is not possible to cover the full scope of the debate here. For a useful outline of the wider debate on see e.g. Fredman (2011), note 1, above.
[57] Reaume (2003), note 4, above though note that for Reaume, dignity may also be infringed by exclusion from certain types of good, necessary for a life with dignity. See further discussion of Reaume's account of dignity, below. See also Moreau who argues that where use of characteristic as a proxy does not involve negative connotations, there is no violation of dignity – although the use of characteristics in this way may still be wrong because interferes with autonomy Moreau (2004), note 20, above.
[58] Dworkin, R. (1985) *A Matter of Principle* (OUP, New York) p.299.

The second response is that positive discrimination is needed to respect the dignity of the disadvantaged group which the positive measure is intended to benefit. Thus for Dworkin it may sometimes be necessitated by the imperative to treat each other with equal respect and concern: 'We can insist that people have political rights to whatever protection is necessary to respect the equal importance of their lives and their sovereign responsibility to identify and create value in their lives.'[59] On this account, reverse discrimination may be necessary to treat a historically undervalued group with equal respect and to ensure access to whatever is needed to create value in their lives. This argument may be used to justify reverse discrimination even if it is accepted that the use of status to determine preferential access to benefits for marginalised group offends the dignity of those who are thereby excluded. Where the dignity of all involved is weighed in the balance, it could be argued, the scales will tip in favour of redressing historical disadvantage.

While dignity features in the ongoing debate on reverse discrimination, dignity has, unlike in the US, been notable by its absence from the (limited) jurisprudence concerning positive action in the UK – where positive discrimination is permitted only with the confines of tight statutory rules – or in the EU; nor has it featured in the analysis of the scope of positive action under the ECHR.[60]

Dignity and justification of discrimination

While some forms of prima facie discrimination cannot be legally justified, many can.[61] One of the difficult questions posed by discrimination law is in what circumstances justification is possible. Within the UK and EU and under the ECHR the question is normally framed by a proportionality test (discussed in chapter one) and there is scope for dignity to influence the application of the test both in determining which aims are legitimate and in assessing how the various interests at stake should be weighed against each other. While there is, in fact, little evidence of dignity being used in this way by the courts, in two recent cases the protection of dignity was argued by the respondents to be a legitimate aim itself.

[59] In (2006) *Is Democracy Possible Here* (Princeton University Press, Princeton) p. 32.
[60] See O'Connell, R. (2009) 'Cinderella comes to the Ball: Article 14 and the right to non-discrimination in the ECHR' 29 (2) Legal *Studies* 211-229.
[61] Article 14 ECHR. See also Equality Act 2010 S19 under which prima facie indirect discrimination can be justified where it is a 'proportionate means of achieving a legitimate aim.'

Seldon[62] was the first opportunity the UK Supreme Court had had to consider the justification test for direct age discrimination under the Equality Act 2010. Mr Seldon, a solicitor and partner in the respondent law firm, had, against his wishes, retired from the partnership at the end of 2006, the year in which he turned 65, in accordance with the provisions of the partnership agreement (to which he had originally agreed). Having failed to persuade the rest of the partnership to amend the agreement to permit him to continue to work for the firm beyond this date, he bought a claim of direct age discrimination and victimisation.

The respondent firm claimed that their treatment of Mr Seldon was justified by a number of aims, of which three were accepted as legitimate aims by the Employment Tribunal. These were (i) ensuring that associates are given the opportunity of partnership after a reasonable period as an associate, thereby ensuring that associates do not leave the firm; (ii) facilitating the planning of the partnership and workforce across individual departments by having a realistic long term expectation as to when vacancies will arise; and (iii) limiting the need to expel partners by way of performance management, thus contributing to a congenial and supportive culture in the Respondent firm. This third aim was not, originally, couched in the language of concern for the dignity of the individual partner or employee but appeared to be about the awkwardness in relations which would result from the existence of a performance management system at this level.

The judgment of the Employment Tribunal was upheld in this respect by the Employment Appeal Tribunal[63] and the Court of Appeal.[64] It was in the Court of Appeal that dignity was first mentioned. In respect of the aim of 'collegiality' Sir Mark Waller readily accepted that this could amount to a legitimate aim capable of justifying mandatory retirement, noting that 'my experience would tell me that it is a justification for having a cut off age that people will be allowed to retire with dignity…[t]here is a very great difference between employees or partners who are under-performing but not by reason of age, and employees or partners who are doing their best but it is no longer good enough because old age has caught up with them.'[65]

[62] *Seldon v Clarkson Wright & Jakes (A Partnership)* [2012] UKSC 16.
[63] [2009] 3 All E.R. 435. The EAT concurred that all three of the aims identified were legitimate; however they held that the respondent firm had not managed to show that a retirement age of 65 was a proportionate means of achieving the aim of collegiality.
[64] [2010] EWCA Civ 899.
[65] ibid. at 23 and 34

The Supreme Court was unanimous that all three aims were legitimate aims, capable of justifying direct age discrimination. Giving the leading judgment, Lady Hale noted that all three aims had been recognised as potentially legitimate by the CJEU in the course of its jurisprudence on Article 6 of the Directive. In fact the CJEU had not used the term dignity itself but had referred to the avoidance of workplace disputes on capability.[66] However, the Supreme Court interpreted this as decisive in relation to 'a dignified retirement' being a legitimate aim. Hale did raise some concerns about the implications of the dignity argument advanced by the employer. Age UK, intervening, had argued that the dignity of each individual was the philosophy underlying all the anti-discrimination laws and that this amounted to a right not to be treated on the basis of stereotypical assumptions.[67] Lady Hale expressed some sympathy with this position, noting that sex based stereotypes – such as the relationship between sex and physical strength – are no longer seen as an acceptable basis on which to deny employment opportunities to women. She conceded that 'it would be consistent with this principle to hold that the fact that most people over a certain age have slower reactions than most people under that age does not justify sacking everyone who reaches that age irrespective of whether or not they still do have that speed of reaction.'[68] Despite these misgivings however, she concluded that the CJEU's acceptance of dispute avoidance/preserving dignity as a legitimate aim was the end of the matter.

Two different versions of dignity are evident in the argument. The dignity that is harmed by the application of a pejorative stereotype, here that individuals are likely to begin to face a decline in mental acuity after the age of 65, is normally associated with intrinsic worth and/or recognition. The use of a negative stereotype conveys the view that the individual or group to which they belong are less worthy than others and therefore fails to show the equal respect and concern mandated by their equal intrinsic worth.[69] The second conception of dignity is that of what constitutes a dignified life; the Court accepted that a dismissal on grounds of diminishing capability related to age was undignified, (apparently irrespective of whether the claimant himself may have found it to be so.) A third possibility was not discussed - the conception of dignity as respect for the autonomy of the individual to decide for him or herself whether to choose to wait and risk a capability procedure (even a humiliating one) at a later stage. Nor was dignity invoked in relation to another of the legitimate aims – that

[66] *Rosenbladt v Oellerking GmbH* [2011] CMLR 1011; *Fuchs and another v Land Hessen* [2011] 3 CMLR 1299
[67] Submission of Age UK (Second Intervener) at. 31
[68] Note 57, above, at 58. See also her judgment in *R (European Roma Rights) v Prague Immigration Officer* [2004] UKHL 55.
[69] For this view see, for example, Reaume (2003), note 4, above; Moreau (2004) , note 23 above.

relating to the sharing of opportunities between the generations – where it could have been used to frame the issue in the language of positive discrimination.

A second recent case in which ensuring respect for dignity was advanced – but ultimately rejected by the Court –as grounds for permitting a discriminatory measure was in *SAS* v *France*.[70] This case, before the ECtHR, involved a challenge to France's ban on the wearing of a full face veil in public. The applicant argued that the ban was a breach of her rights under Articles 8, 9 and 10 of the ECHR and was indirectly discriminatory under Article 14. The Court eventually determined that although the applicant's Convention Rights were engaged, the interference with the applicant's rights was justified on grounds that it was a proportionate means of achieving the legitimate aim of preserving the right of others 'to live in a space of socialisation which makes living together easier.'[71] However, in the course of argument the respondent government had advanced another legitimate aim – that of protecting dignity – which was rejected by the Court.[72] The Court were unpersuaded that the protection of dignity was a legitimate aim on the facts because, it argued, the government did not 'have any evidence capable of leading it to consider that women who wear the full-face veil seek to express a form of contempt against those they encounter or otherwise offend against the dignity of others.'[73] In the view of the Court, therefore, the dignity interest at stake was that of others sharing a public space with those who chose to wear the veil. While they rejected the assertion that permitting the wearing of the veil would in fact 'offend' the dignity of others (or at least required further evidence of it), they did not reject the idea that the protection of dignity may in principle justify the banning of practices which did represent the expression of contempt for others.

In fact, and as Adenitire points out, the French Government had expressed their dignity argument rather differently. Rather than suggesting the covering of the face expressed contempt for others they had argued that women who wore the veil were 'effaced' from public space and that 'whether such "effacement" was desired or suffered, it was necessarily dehumanising and could hardly be regarded as consistent with human dignity.'[74] On this view, then, by contrast, it is the dignity of the claimant and others who may wear the veil that

[70] [2015] 60 EHRR 11.
[71] ibid at 122.
[72] ibid. Gender equality was also advanced as an aim by the government but as something separate from the protection of dignity rather than as something required by it.
[73] ibid.at 120.
[74] Ibid at 82. See discussion in Adenitire, J. (2015) 'Has the European Court of Human Rights recognised a legal right to glance at a smile?' 131 (Jan) *Law Quarterly Review* 43-48.

is under threat. Interestingly dignity was barely mentioned by the claimant in her argument before the court other than to note that the government's argument that women who wore the veil were effaced was based on stereotyping and chauvinism and that the disapproving response of others to the veil, even if invoking human dignity, needed to be weighed against the serious infringement of her rights that the ban represented.[75] She did not attempt to argue that her own dignity was infringed by the constraint on her autonomy to act in accordance with her own deeply held religious beliefs.

These uses of dignity by the respondent law firm in *Seldon* and the French Government in *SAS* represent what Beyleveld and Brownsword have identified as 'dignity as constraint.'[76] Dignity is not associated with autonomy and the right of individuals to make choices according to their own version of the good life but instead is associated with requiring individuals to conform to a community defined view about what is dignified for them. As Rao (writing before *SAS*) puts it, the use of dignity evident in arguments such as that used by the French Government 'is not respect for the equal human dignity of each woman as an individual agent but rather a paternalistic (at best)…decision about what makes women dignified.'[77]

Canada

The fairly limited use of dignity in Equality jurisprudence in the UK, EU and ECHR stands in contrast to that in other jurisdictions such as Canada and South Africa where it has formed the basis of the interpretation of constitutional Equality Guarantees – though, since *Kapp,* it no longer serves this role in Canada. The approach of the Canadian Supreme Court was outlined earlier in the chapter. It is worth revisiting some of the Canadian jurisprudence in more detail here as it provides a useful illustration of the meanings that may be ascribed to dignity in the non-discrimination context and at some of the difficulties these present. Two cases in particular will be considered here, both of which concerned the use of age to determine eligibility for benefits: *Law*[78] which devoted a lengthy portion of the judgment to an explanation of what dignity requires and the later case of *Gosselin*[79] which has attracted particular criticism for the way in which the concept of dignity was applied.

[75] ibid at 77 and 78.
[76] Beyleveld, D. and Brownsword, R. (2001) *Human Dignity in Bioethics and Biolaw* (Oxford, OUP)
[77] Rao, N. (2011) 'Three concepts of dignity in constitutional law' 86 *Notre Dame Law Review* 183 at p.228.
[78] *Law v Canada*, note 9, above.
[79] *Gosselin v Quebec* [2002] SCC 84

The Supreme Court's approach to dignity, first set out systematically in *Law*, was noted earlier in the chapter. The case concerned a measure restricting the availability of survivors' pension benefits to those over the age of 35 (or those with dependants or with disabilities.) It will be recalled that Iacobacci identified the protection of human dignity as the fundamental purpose of s.15 of the Canadian Charter. He acknowledged that there can be different conceptions of what human dignity means but went on to provide the following definition for the purposes of the Charter:

> '[T]he equality guarantee in s.15(1) is concerned with the realisation of personal autonomy and self-determination. Human dignity means that an individual or group feels self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment. Human dignity is harmed by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities or merits. It is enhanced by laws which are sensitive to the needs, capacities, and merits of different individuals, taking into account the context underlying their differences. Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society. Human dignity within the meaning of the equality guarantee does not relate to the status or position of an individual in society per se, but rather concerns the manner in which a person legitimately feels when confronted with a particular law. Does the law treat him or her unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law?'[80]

He went on to explain that the determination of whether a contested measure demeaned the dignity of the claimant was an objective test to be assessed by reference to four contextual factors, which he stressed were not exhaustive and may not all be present in any particular case. These are: (i) the existence of pre-existing disadvantage or stereotyping; (ii) whether the treatment or policy in question corresponds to the individual's circumstances; (iii) whether the treatment or policy is intended to improve the situation of a disadvantaged group; and (iv) the significance of the interest affected.[81]

At least two different conceptions of dignity are evident here.[82] On the one hand dignity is linked to autonomy and self-determination; on the other to feelings of self-worth and self-respect, though the legitimacy of these feelings is to be assessed against an objective

[80] Note 9, above, at 53.
[81] ibid at 62-75.
[82] Fyfe argues that 'a medley of dignity conceptions' are evident in Iacobucci's definition and that this has resulted in confusion in the subsequent case law where different versions of dignity are reflected in different decisions. Fyfe, J. (2007) 'Dignity as Theory: Competing Conceptions of Human Dignity at the Supreme Court of Canada' *Saskatchewan Law Review* 70, 1-26.

standard. These conceptions are not necessarily incompatible; measures which undermine autonomy and self-determination may be argued to also convey a judgment about the lesser worth of those affected (however those affected may in fact feel).[83] However, a number of commentators, even those who approve of the general direction of the Court, have had difficulty with the way dignity has been defined and applied in *Law* and in the subsequent case law. [84] Of particular concern is the way the 'self-worth' aspect of the test has been used by the Court to permit measures excluding claimants from a range of benefits because they have determined that the measures are not demeaning. In doing so the Court have not always been able to explain consistently the basis on which certain measures are demeaning while others are not, and have apparently ignored the other aspects of dignity outlined in Iacobacci's definition in *Law*, including the self-determination aspect. Thus in *Law* itself the Court eventually held that there was no violation of s.15 because the use of the age distinction to exclude younger widows or widowers from pension benefits did not 'reflect or promote the notion that they are less capable or less deserving of concern, respect and consideration' or 'perpetuate the view that people in this class are less capable or less worthy of recognition or value as human beings or members of Canadian society.'[85]

A similar approach was evident in *Gosselin*[86] which concerned a challenge to a social assistance scheme under which welfare benefits were payable at a lower rate to those under 30. In approaching the question of whether this provision breached the s.15 equality guarantee under the charter of fundamental rights, the court, applying the test established in *Law*, considered whether the treatment of the claimant constituted an affront to her dignity. They concluded it did not. In reaching this conclusion, consideration was given to the four contextual factors. Factor (iii) was deemed to be irrelevant on the facts and there was considerable factual disagreement in relation to factors (ii) and (iv). In relation to (i) it was argued that 'The fact that "each individual of any age has personally experienced all earlier ages and expects to experience the later ages" (P. W. Hogg, Constitutional Law of Canada (loose-leaf ed.), vol. 2, at p. 52-54) operates against the arbitrary marginalization of people in a particular age group. Again, this does not mean that age is a "lesser" ground for s. 15 purposes. However, pre-existing disadvantage and historic patterns of discrimination against

[83] See Reaume (2003) note 4, above, and discussion below on this point
[84] See, for example,
Grabham, note 17, above; Moreau (2004) note 23, above; Reaume (2003) and (2013) note 4, above; Fudge, note 18, above; Fredman (2007) note 20, above.
[85] Note 9, above, at 99, 107, 108
[86] Note 79, above.

a particular group do form part of the contextual evaluation of whether a distinction is discriminatory, as called for in Law.'[87] McLachlin, for the majority, concluded that because of this, and because of the findings of fact made in respect of the other factors, the welfare programme did not treat younger people as less worthy or less deserving of respect in a way that had the purpose or effect of marginalizing or denigrating younger people – and indeed served to promote their 'self-sufficiency and autonomy.'[88] There was therefore no denial of human dignity involved.

The approach of the Supreme Court in *Gosselin* has attracted considerable criticism. In a dissenting judgment L'Heureux Dube disputed the finding that the distinction made was not demeaning: 'I see no other conclusion but that Ms. Gosselin would have reasonably felt that she was being less valued as a member of society than people 30 and over and that she was being treated as less deserving of respect.'[89] Similarly the Women's Court of Canada – an academic project to reimagine and rewrite some of the decisions of the Supreme Court – strongly contested the view that there was no stereotyping involved in the use of age to determine access to the welfare benefits involved: 'The scheme discriminates by withholding social assistance from a group of destitute people, legislatively identified by their age, based on prejudice and stereotypical assumptions about their needs, capacities, and circumstances…The scheme thereby violates essential human dignity, and, on the basis of this stereotyping alone, it is discriminatory.'[90]

Moreau argues that the narrow approach of the Supreme Court in cases like *Gosselin* stems from the failure of the court to recognise the range of harms which unfair discrimination may cause, not all of which implicate dignity directly. For Moreau, the difficulty in the approach of the Supreme Court is that it appears to treat the narrow form of dignity – diminishing self-worth – as the sole harm caused by unfair discrimination.[91] Where there is no evidence of diminished self-worth, as the Court found to be the case in *Gosselin*, the conclusion is that the treatment was therefore not unfair discrimination. 'To the extent that the Law test reduces "dignity" to an experiential good (albeit one that is assessed from the perspective of a

[87] Ibid at 32.
[88] Ibid at 65.
[89] Ibid at 133.
[90] The Women's Court of Canada is a project which involves academics and lawyers reimagining the jurisprudence of the Supreme Court. Their 'alternative' judgments on *Gosselin* are available at http://www.thecourt.ca/2009/07/08/the-womens-court-of-canada-gosselin-v-quebec-attorney-general-2006-1-w-c-r-193/ (accessed August 2015)
[91] Moreau (2004) note 20, above.

reasonable person in the claimant's position), it mistakenly tries to treat what can at most be one of the wrongs involved in discrimination as a full and complete account of these wrongs.'[92] Thus the other harms caused to the claimant in *Gosselin*, chiefly her exclusion from a level of benefits needed for basic subsistence because of the application of a stereotype (even in the event it could be characterised as an accurate one) were ignored.

An alternative approach to treating dignity as just one of the harms unfair treatment may involve is offered by Reaume who has attempted to construct an account of dignity, against the backdrop of Canadian equality jurisprudence, which attempts to avoid many of these difficulties.[93] Her starting point is that legislative distinctions convey social meanings quite apart from how those on the receiving end of those distinctions feel about them.[94] Those distinctions which imply that the excluded (or included) group is less valued involve a particular harm to dignity (separate from the exclusion from the benefit itself) because human dignity requires that all are valued equally. This harm can be caused in three ways. First where the distinction is based on prejudice, defined as the attribution of negative worth to personal characteristics which are important to identity, or, in the case of characteristics such as age or disability, for example, using characteristics to reduce the person to one aspect of their identity. The second is distinctions based on stereotypes, defined by Reaume as 'inaccurate generalizations about the characteristics or attributes of members of a group that can usually be traced back to a time when social relations were based more overtly on contempt for the moral worth of the group.'[95] This does not appear to cover cases where reasonably accurate generalisations are drawn leading to the use of a characteristic as a proxy. For Reaume, these two means of harming dignity are relatively straightforward to spot and apply, though she notes the crucial importance of historical social and cultural context in doing so.

More difficult is the third route to harming dignity, and one which she argues has been recognised but then largely ignored by the courts. This is where the benefit or good from which the individual is excluded is itself important to a life with dignity. This, Reaume suggests, will include benefits which relate to respect for an individual's identity and respect for the ability of an individual to freely pursue their own plans and projects. Thus, she argues,

[92] Ibid. at p. 25.
[93] Reaume (2013), note 4, above.
[94] For a similar view see Khaitan, T. (2012) 'Dignity as an Expressive Norm: Neither Vacuous Nor a Panacea' *Oxford Journal of Legal Studies* 32, 1-19
[95] Reaume (2003), note 4, above, at p. 681.

legislative distinctions which deny recognition (such as those which leave benefits unavailable to same sex couples) or which compromise autonomy (such as non-provision of sign language for deaf patients to enable them to consent to medical treatment) or which leave individuals without means of basic subsistence, all implicate dignity. On this account, even if neither prejudice nor inaccurate stereotyping were behind the legislative distinction in *Gosselin* (which is contested) it still resulted in harm to dignity because it meant extreme poverty for those young adults who in fact had no parental support, or a lack of autonomy for those who did have parental support and were thereby forced to depend on it.

Conclusion

The above discussion has aimed to identify some of the key meanings given to the concept of dignity in relation to anti-discrimination law. A number of different, related, versions are evident. These include autonomy, freedom from humiliation or diminished self-worth (whether this is judged from the perspective of the individual or that of wider society), recognition (of both individual and group characteristics) and access to the means to live a dignified life. Several of these conceptions are linked by the moral imperative not to treat others in a way which communicates that they are less valued as human beings. The following and final chapter will assess the implications of these meanings of dignity, together with those identified in chapter six, for the question of when age discrimination in health care is justifiable.

CHAPTER EIGHT: CONCLUSION

Introduction

This thesis set out to investigate which types of age based distinctions, in access to publicly funded health care, respect for human dignity may permit. Chapter two identified a number of examples of the uses of age in determining access to health care which those involved in its provision may wish to justify and retain. In particular it was seen that age is used as a proxy for a range of factors including the risk that patients may develop certain conditions and the capacity of patients to benefit from particular treatments. A number of possible reasons for using age in this way were identified, including the maximising of efficiency and the best interests of the patient. Chapter three then outlined the legal framework governing use of personal characteristics as proxies in decision making and explored the reasons, evident in the jurisprudence, as to whether and when it is permissible to use personal characteristics in this way. It was seen that one approach to the use of age to determine access to benefits has been to distinguish age from other characteristics such as sex and race on the basis that age based rationing does not create inequality where this is assessed over a whole lifetime rather than at a particular moment in time (the 'complete life view'). This argument was then explored in detail in chapter four. It was suggested there that at least *some* instances of the use of age as a proxy may give rise to harms which cannot be discounted or justified by reference to a complete life view; and that (at least some of) these harms may relate to the moral requirement to respect human dignity. Chapters five, six and seven then reviewed the different meanings ascribed to dignity in legal contexts of particular relevance to these issues.

This final chapter now explores whether the uses of age identified in chapter two are compatible with different conceptions of dignity evident in health care and anti-discrimination law. In particular it will seek to assess what dignity related harms these uses of age to limit access to health care resources may cause. The first section identifies the dignity harms to which age based rationing may give rise by assessing the uses of age against two broad conceptions of dignity: dignity as requiring state provision of the means to live a dignified life; and dignity as communication of equal worth. The second section then turns to consider whether, where dignity harms arise, the uses of age in this way can nonetheless be justified. It will be remembered from earlier chapters that while some accounts of dignity hold that dignity is inviolable and that therefore interference with dignity interests can never be justified, many treat dignity as a right or interest to be weighed alongside other rights or

interests (including the dignity of others) when assessing whether a particular course of action can be justified. Two main strands of justification for age discrimination are therefore considered. First that the use of age based distinctions may be in the best interests of the individual patient; and second that the use of age to ration may be justified by reference to the need for an efficient and fair means of resource allocation. The compatibility of these potentially 'legitimate aims' with different conceptions of dignity is assessed. The chapter concludes by considering the implications of this dignity assessment of age discrimination for approaches to legal justification. It will be argued that while action which harms the dignity interests of an individual may sometimes be justified (for example in the dignity interests of others) dignity harms cannot be readily discounted or justified by taking a complete life view. In respect of these harms it is difficult to maintain a plausible difference between age and other protected characteristics. For this reason courts should be wary of engaging in lighter touch review of justification of age discrimination on the grounds that 'age is different,' whenever dignity interests may be involved.

Dignity harms

Dignity as requiring provision of basic goods needed for a dignified life

The use of age (or indeed any criterion) to ration health care may result in an individual not receiving all of the health care they need or would choose. The consequences of this for the individuals concerned will, of course, vary enormously depending on the type and seriousness of the need and the effectiveness of the treatment refused or delayed. Denial of some forms of health care provision may also result in dignity related harms. It has been seen that, on one conception of dignity, dignity is violated, or is not respected, where an individual is denied the goods needed for a dignified life. Definitions of a dignified life vary between different accounts of dignity. On some, the dignity harm is caused where there is a failure to provide certain basic requirements to enable humans to function as autonomous agents, to realise their own identity and to pursue their own plans and projects. On other accounts, the dignity harm arises where a lack of provision results in individuals having to exist in an 'undignified state.' Where these conceptions of dignity are used, dignity-based arguments against age rationing will therefore focus on the consequences of the denial of the particular intervention for the individual concerned. They do not depend on comparison with what others have received. However, the denial of goods needed for dignity to a particular group

may also give rise to a second dignity harm – the communication that the group is less valued.

Inevitably a much more detailed consensus on the requirements of dignity is needed to determine whether any particular instance of rationing gives rise to these type of dignity harms. The case law has shown that what amounts to a 'dignified state' – or perhaps, better, a 'dignified health related quality of life' - is sometimes treated as an objective matter (such as in *McDonald*) and is sometimes determined by reference to the views of the patient (as in *Burke*). A subjective approach will, of course, mean that what amounts to dignity or indignity is likely to vary between individuals. As Munby put it in *Burke,* 'we have to remember that views as to what is dignified or undignified are highly personal. What is dignified to one may be undignified to another.'[1] In addition, and as Munby was careful to point out in *East Sussex,* views (both subjective and objective) as to what amounts to indignity may depend on cultural context and may change over time in line with our expectations of what medical intervention can achieve.

The survey of uses of this conception of dignity in health care law in chapter six suggested that, as a minimum, dignity is likely to be threatened by health conditions (and medical interventions) which are experienced as humiliating or are so distressing as to threaten physical or psychological integrity, or a patient's strongly held sense of identity. Many of the cases in which dignity has been considered in this way concern extreme suffering at the end of life. While examples of indignity such as those discussed in *Burke*, involving the potentially extremely distressing consequences of a withdrawal of artificial nutrition, may be relatively straightforward to identify,[2] other cases are more difficult. In particular it may be more difficult to agree on whether and when the consequences of refusing life prolonging treatments may include harm to the dignity interests of the patient. On the one hand, earlier death will self-evidently cut short the individual's ability to pursue their own plans and projects in many cases, as well as potentially increasing the distress and anxiety for the individual concerned and those close to them. On the other, the prolonging of life was identified with indignity rather than with dignity in *Bland* and in the 'right to die' cases discussed in chapter six because it involved the prolonging of existence (against the wishes of the individuals themselves) which had or would become physically and mentally intolerable.

[1] [2004] EWHC 1879 (Admin) at 66.
[2] Although, again, even here Munby noted that 'we must guard against assuming that ANH is in all circumstances a good thing conducive to human dignity merely because that is, if indeed it is, the claimant's strongly held view.' ibid.

In these cases, of course, there was no conflict between this 'dignified state' conception of dignity and the 'autonomy-dignity' conception because the individuals themselves wished to be relieved from the indignity of their condition. But where, for example, a patient wishes to undergo a procedure which may prolong life but which (they are fully aware) carries a significant risk of leaving them in physical and/or psychological distress as a result, these different approaches to dignity may provide different answers.

Leaving aside matters of life and death, and examples of severe physical and psychological distress, there is obviously scope for considerable debate as to what the minimum – health related – requirements for a dignified life are. There has been, as discussed briefly in chapter six, some useful research on this aspect of dignity in the context of social care, some of which may be deployed in the health care setting to determine whether a particular intervention is needed to meet this dignity standard. Procedures which are necessary to facilitate independence and social inclusion, for example, are likely to be strongly associated with respecting dignity, particularly versions of dignity which prioritise autonomy. So too are those which are deemed integral to enabling an individual to maintain their own identity. The category of health interventions which engage the question of dignity is potentially very broad. Thus, for example, and relevant to one of the few explicit uses of age based rationing discussed in chapter two, denial of IVF (at any age) may be argued to involve harm to the dignity interests of the individuals concerned, because of the close link, recognised by the courts in *Evans*, between reproductive choices and identity.

Foster has argued that the QALY methodology, while imperfect, is a good example of dignity in action because in its focus on quality of life it incorporates regard for human thriving. The existing methodology for calculating health related quality of life, the EQ-5D, does indeed incorporate aspects of obvious relevance to the notions of a dignified life outlined above (mobility, self-care, pain/discomfort, anxiety/depression and ability to carry out 'normal' activities.)[3] However, the QALY methodology is concerned with only with relative improvements in health related quality of life which will potentially be bought about by a particular intervention, rather than with the absolute level of quality of life before and after intervention. It is not a tool which, used alone, is capable of ensuring that health care will always be deemed cost effective, or required, where it serves to improve the health related quality of life of those whose starting point is very low or where it allows individuals to reach

[3] See NICE Decision Support Unit (2010) *The Incorporation of Health Benefits in Cost Utility Analysis Using the EQ-5D* (ScHARR, Sheffield).

a minimum basic threshold of quality of life. The QALY has also been criticised for its inability to accommodate the need to provide a minimum threshold of care for those who would remain largely unaware of the impact of improvements upon their well-being. Thus Herring has argued that the QALY approach can produce unacceptable results because 'in particular, it places no weight on concepts such as dignity. A severely mentally ill person with no real awareness of what is happening to them could be left in appalling circumstances on the basis that to offer them basic care would not improve their quality of life because they lack awareness of their condition.'[4] It will be remembered that the court was clear, in *Bland*, that dignity may be threatened even in circumstances where the patient can have no awareness of their condition or treatment. Finally, because remaining life expectancy is combined with improvements in quality of life to calculate the number of QALYs an intervention may produce, the methodology, at least in theory, leaves open the possibility of denying interventions to individuals with not long left to live, even where this results in them living the rest of their life in a very poor, below dignity, state of health. Thus Foster acknowledges that palliative care is a particular problem for the QALY.[5]

The challenge for anti-age rationing arguments, based on this 'dignified life' conception of dignity, is to identify and defend a threshold of health related quality of life, below which dignity interests are threatened. Denial of intervention necessary for an individual to stay above that threshold will harm the dignity interests of that individual. It is of course plausible that there may be a scale of dignity harms such that some health conditions pose more of a threat to dignity interests than others. If so, this would then be relevant to the question of when denial of treatment because of age may be justified, with the harm to dignity interests weighed in an analysis of proportionality. The more serious the harm to dignity, the more difficult to justify the age based exclusion.

It will be remembered that the moral requirement to help those who are in particular need, was one of the objections to the complete life view of equality raised in chapter four. On this view we may have obligations to assist those whose health related quality of life is very poor today, even if this means the individuals concerned will have more than their equal share of resources when this is assessed across a lifetime. An obligation to provide adequate pain relief or palliative care, irrespective of the overall lifetime distribution of resources, is an

[4] Herring, J. (2012) *Medical Law and Ethics* (Oxford, OUP) p. 81
[5] Foster, C. (2011) *Human Dignity in Bioethics and Law* (Hart, Oxford). See also Hughes, J. (2005) 'Palliative Care and the QALY Problem' *Health Care Analysis* 13(4) 289-301.

obvious example. This notion of priority is often located within an egalitarian framework but also has much in common with 'dignified life' accounts of what dignity requires.[6] Indeed advocates of dignity may argue that respect for human dignity is a source of this moral obligation to help the very badly off today, irrespective of their lifetime share of goods. On this account, an individual who is denied an intervention because of age, where the result is that they continue to endure very poor health related quality of life, will suffer harm to their dignity interests and one that cannot be answered by appeal to the complete life view of equality. It does not matter that, over their lives, they will have had higher than average health related quality of life or share of resources. If this conception of dignity in engaged, the complete life view is not sufficient to justify restriction on access to care because of age where that care is needed to achieve a minimum threshold of health necessary for dignity.

Recognition dignity and communication of unequal worth

Two, related, conceptions of dignity were among those evident in the review of discrimination law in chapter seven. These were, first, the idea that dignity requires recognition of individuality; and that, second, any measure which suggests that those affected by it are of lesser worth than others is an infringement of dignity. The use of pejorative or demeaning stereotypes as a basis for rationing will be incompatible with both of these accounts of dignity. As Fredman notes, this kind of prejudicial treatment constitutes a basic failure of recognition and therefore a violation of dignity because it is capable of humiliating or degrading those to whom it is directed.[7] Negative stereotypes, for example that older people are less capable or are passive and dependent, are certainly evident in accounts of treatment of older people in health and social care.[8] However, because the focus here is on uses of age which may be, at least arguably, justifiable, overtly negative connotations are largely absent from the particular uses of age as a proxy identified in chapter two where, in many cases, age stands as a proxy for physiological condition rather than any feature of personality. It is more difficult to conceive of such uses of age as derogatory in and of themselves. In what respects, then, might the uses of age as a proxy identified in chapter two be incompatible with these accounts of dignity?

[6] See, for example, Parfitt, D. (1997) 'Equality and Priority' *Ratio* 10(3) 202-221.
[7] Fredman, S. (2011) *Discrimination Law* (OUP, Oxford) at p.29.
[8] Tadd, W. and Calnan, M. (2009) 'Caring for Older People: Why Dignity Matters – the European Experience' in Nordenfelt, L. (Ed.) *Dignity in Care for Older People* (Blackwell, Oxford)

It is sometimes argued that the meaning of distinctions based on certain characteristics may arise at least in part from their social and historical context. This context may imbue uses of these characteristics with a demeaning message even where they are not used in an otherwise derogatory way. This view is sometimes evident in the approach of the courts to distinctions based on, for example, sex or race, which do not otherwise appear to carry any negative connotations. Thus the existence of historical disadvantage was one of the contextual factors identified in *Law* and used by the courts to distinguish between distinctions which violated dignity and those which did not. The absence of an association between the use of a characteristic and historic group disadvantage is also sometimes used to justify positive discrimination. Thus, as was discussed in chapter seven, it is argued where it is the – historically privileged – group which is excluded from a particular benefit, the use of a characteristic to make a distinction carries no implication that the excluded group has less inherent worth than included group and is therefore no affront to dignity.

The absence of pre-existing group disadvantage has also been used to distinguish age discrimination from discrimination on the basis of other characteristics. Thus, for example, the US Supreme Court explained in *Murgia* that age based distinctions required less intensive scrutiny than those based on race or sex because '[w]hile the treatment of the aged in this Nation has not been wholly free of discrimination, such persons, unlike, say, those who have been discriminated against on the basis of race or national origin, have not experienced a "history of purposeful unequal treatment" or been subjected to unique disabilities on the basis of stereotyped characteristics not truly indicative of their abilities…even old age does not define a "discrete and insular" group… in need of "extraordinary protection from the majoritarian political process." Instead, it marks a stage that each of us will reach if we live out our normal span.' [9]

There seem to be two aspects to this type of argument. First, while research demonstrates the existence of persistent and ongoing discrimination against certain age groups across a range of activities from employment to health care, this is not something true of every age group and therefore of 'age' in general. This was a point made by McLachlin in *Gosselin* which, it will be remembered, concerned a provision which denied access to a particular benefit to

[9] *Massachusetts Board of Retirement v Murgia* [1976] 427 U.S. 307 at 426-7 citing *United States v. Carolene Products Co.*[1938] 304 U. S. 144; and see discussion in Rutherglen, G. (1995) 'From Race to Age: The Expanding Scope of Employment Discrimination Law' *The University of Chicago: The Journal of Legal Studies* 24, 491

those under the age of thirty. She argued there that 'age based distinctions…do not automatically evoke a context of pre-existing disadvantage suggesting discrimination and marginalization under this first contextual factor, in the way that other enumerated or analogous grounds might…. Concerns about age-based discrimination typically relate to discrimination against people of advanced age who are presumed to lack abilities that they may in fact possess. Young people do not have a similar history of being undervalued. This is by no means dispositive of the discrimination issue, but it may be relevant.'[10]

The second point relates to the complete life view of equality. The argument appears to be that because we should all pass through each age stage, no individual can be said to be subject to pre-existing disadvantage as a result of age and the use of age as a characteristic is therefore not demeaning. Thus even where a particular age group is subject to historic and ongoing disadvantage, those who are members of that group at any particular time will not themselves have been subject to historic *age related* disadvantage because it is a group which they can only have recently joined. This type of reasoning appears to have been behind the comments of Lord Walker in Reynolds to the effect that distinctions made on the basis of age may be 'disheartening' but that they are not 'demeaning' in the same way as are distinctions made on the basis of sex.[11] To this it may be replied of course that membership of some groups such as the 'over 50's' may last almost half a lifetime and that once you join this group your membership is permanent. For those who have been 'old' for some time, it may make sense to speak of a history of disadvantage and stigma attaching to age. And in relation to discrimination affecting younger age groups it should be remembered that exclusion from a benefit at a particular age may create lasting disadvantage even where membership of the group is only temporary. Refusal to provide funded IVF treatment because of age may be an example of this.

In any event, while historical discrimination and pre-existing disadvantage may be important reasons, or indeed sufficient conditions, to conclude that the use of particular personal characteristics is demeaning, or undermines dignity, they may not be necessary conditions. As Moreau notes, there is a wrong associated simply with treating someone as a member of a group rather than as an individual in some contexts.[12] This is certainly reflected in the protection afforded by the UK and EU anti-discrimination framework and under the ECHR

[10] *Gosselin v Quebec* [2002] SCC 84 at 31-2.
[11] *R (on the application of Reynolds) v Secretary of State for Work and Pensions* [2006] 1 AC 173 at 60.
[12] Moreau, S. (2004) 'The Wrongs of Unequal Treatment' *University of Toronto Law Journal* 57(2) 291-326. Moreau explains the wrong here as being an arbitrary restriction of autonomy.

which is, largely, symmetrical. Members of the majority or advantaged group, as well as the minority, are protected in respect of direct discrimination and harassment, though group disadvantage is necessary for indirect discrimination.[13] In respect of other characteristics, as noted in chapter three, the UK courts and the CJEU have shown persistent concern that a failure to treat somebody as an individual may be harmful independently of any other disadvantage or inequality it may create and even where this does not involve the use of an inaccurate or pejorative stereotype. In *Law v Canada* it had been argued that, among other things, 'human dignity is harmed by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities or merits.'[14] It will be remembered from chapter four that the importance of recognition of individual characteristics was one suggestion of a synchronic interest which is harmed by the use of status to discriminate.

The relevant conception of dignity here is that associated with recognition of individual characteristics and qualities. Respect for 'recognition dignity' has been characterised as requiring, among other things, recognition of individual uniqueness; it certainly militates against reducing individuals to one aspect of their identity which they share with other members of a group. Even where no negative connotations are associated with a particular use of a characteristic, conceptions of dignity which place importance on recognition of individuality will have difficulty in accommodating generalisations based on group characteristics, even where these are not (obviously) negative or derogatory to those concerned. This is most obviously true of generalisations which are inaccurate. The less accurate the proxy, the less likely it is to be relevant to the needs, capacity or merits of the particular individual to which it is applied. In addition, the less accurate the proxy the more individuals are likely to fall on the wrong side of it and thus to be denied goods important for dignity in the first sense discussed above – having access to the goods required in order to live a dignified life. In *Gosselin*, dissenting, L'Heurex Dube argued, the provision in question violated dignity and breached the applicant's S15 rights for precisely this reason: 'there should be a strong presumption that a legislative scheme which causes individuals to suffer severe threats to their physical and psychological integrity as a result of their

[13] Equality Act S19.
[14] [1999] 1 SCR 497 at 53.

possessing a characteristic which cannot be changed, does not adequately take into account the needs, capacity or circumstances of the individual or group in question.'[15]

The accuracy of some of the uses of age identified in chapter two has been disputed. Thus, for example, it will be remembered that evidence on the prevalence of certain cancers among particular age groups suggest that some of the current age limits for access to screening fail to accurately reflect the likelihood that the individual may be at risk of the disease and would benefit from a screening test. In addition to this evidence on existing limits, Grimley Evans has argued that chronological age does not serve as an accurate proxy for health related risks or capacity to benefit at all for two reasons. First, because there can be wide variance between the chronological age of an individual and their biological age. Second, and related, because, even though there may be correlation between age and health, age is not the cause of anything: 'We have grown so inured to using a patient's age as an excuse for laziness in investigating him or her properly that we have failed to build into our scientific paradigms proper identification of the true physiological determinants of outcome…If one knows enough about the physiological condition of the patient, age should drop off the end of the predictive equation for outcome.'[16] The existence of correlation without evidence of cause was precisely the reason given by the Advocate General in *Tests Achats* for rejecting the use of sex as a proxy for motor insurance risk.[17]

What if the proxy is reasonably accurate however? In what way might the use of an accurate and non-derogatory statistical generalisation compromise dignity? Arguments against the use of these types of statistical generalisation are often framed in terms of autonomy.[18] This is because decisions made without regard for ways in which each individual may differ from others in the group with which they share the characteristic may be argued to fail to recognise and respect individual characteristics which have come about as the result of autonomous decision making. They therefore fail to respect the capacity – past, present and future - of individuals to make autonomous choices. Thus, for example, Eidelson argues that the wrong of basing decisions on statistical generalisations without regard for individual characteristics lies in a failure to pay attention to the way an individual has constructed their life and their

[15] Note 10, above, at 135.
[16] Grimley Evans, J. (2003) 'Age Discrimination: Implications of the Ageing Process' in Fredman, S. and Spencer, S. (ed.'s) *Age as an Equality Issue* (Hart, Oxford) p.19-20.
[17] *Association Belges des Consommateurs Test-Achats ASBL* v *Conseil des Ministres* (C-236/09), Opinion of Advocate General Kokott delivered on 30 September 2010
[18] See, for example, Moreau, note 12, above and Eidelson, B. (2013) 'Treating People as Individuals' in Hellman, D. and Moreau, S.(ed.'s) *Philosophical Foundations of Discrimination Law* (OUP, Oxford).

continuing ability to do so. This wrong, he notes, can occur with benign as well as with derogatory stereotypes because either type of generalisation fails to recognise that each individual has unique character traits bought about by the autonomous decisions they have made: 'Like those who regard black people as endemically violent or promiscuous, those who took them to be loyal or compassionate by nature thereby demeaned their standing as autonomous agents.' Accounts of dignity which place significance on respect for autonomy may then, for these same reasons, find dignity to be incompatible with decisions made about individuals on the basis of their group characteristics. As Raz puts it '[r]especting human dignity entails treating humans as persons capable of planning and plotting their future.[19]'

It is not clear that this part of Eidelson's account applies as easily to use of status such as age as a proxy for biological fact. The uses of age as a proxy identified in chapter two are, by and large, not related to personality or capacity, ability or merit – the features of our individuality which are most readily understood as having been shaped by autonomous choices - but instead to our physiological condition. My ability to endure a general anaesthetic, for example, doesn't seem to implicate my previous autonomous choices in the same way as does my ability to drive safely. This is not wholly true of course. It is common knowledge that lifestyle choices have a very significant impact on my chances of developing a particular disease or of responding in a certain way to a particular intervention. They are also an important contributor to the potentially wide gap between chronological and biological age.[20] In this sense assumptions made about my physiological condition because of my chronological age may fail to pay sufficient due to my autonomous choices.

Eidelson is clear that he is not suggesting that statistical evidence is not useful, but merely that it should not suffice where there is reasonable opportunity to also consider the individual characteristics of each of those affected. There will, he acknowledges, be situations in which it is simply not possible, or not reasonable, to consider each individual on their own merits (though we should be careful not to resort to such arguments too readily). In such situations, he argues, we can fail to treat people individually without failing to treat them as individuals. Where the information necessary for individual assessment is not reasonably available, then there is no disrespect inherent in the application of the generalisation. Even where individual assessment is possible, 'Information about the tendencies of that class is genuine information about its members, but it is not information that reflects their own autonomous commitments.

[19] Raz, J. (1979) *The Authority of Law* (Clarendon, Oxford) at 221.
[20] See Grimley Evans, note 16, above.

According to the autonomy account, there is nothing wrong per se with making use of such information. But the character condition does require that one also consider relevant information that *does* manifest a person's self-authorship.'[21]

The point is, of course, that where chronological age may assist a clinician towards identifying the correct diagnosis of symptoms or the best treatment for a condition we would not wish them to ignore it but nor would we wish them to ignore evidence that might distinguish us in a relevant way from others of the same age. Indeed it has been seen that dignity is often strongly associated with the need for recognition of groups as well as of individuals. Respecting the dignity of groups requires that statistical information about the experiences, needs and disadvantages faced by particular groups be taken into account when designing policy in order to be sensitive to and to accommodate relevant differences. The appropriate design of mental health services, discussed in chapter two, may be a good example of the need to incorporate recognition both of group characteristics and of individual characteristics. On the one hand there must be recognition that older people with mental health conditions are more likely to have particular mental health needs and services need to be responsive to that. On the other hand, there is a need to recognise the significant minority of individuals accessing services whose needs are distinct from others in their age group and for whom services designed around the likely needs of the majority would be largely inappropriate.

In chapter three it was seen that the possibility of making an exception to a general rule, together with the accuracy of a proxy have both (though not always) been judged to be relevant in judicial assessment of whether its use is permitted. These factors are likely to be of particular importance in a proportionality analysis where – if a better and more accurate proxy or individualised test is available for example - it may serve to demonstrate that a less discriminatory means was available to achieve a particular aim. When might it be possible to argue that an individualised assessment is not reasonably possible? We have seen that clinicians have been accused of laziness in relation to the use of age proxies and of course this is unlikely to pass any test of reasonableness. However, while laziness is unlikely to amount to justification for use of a proxy where a more individualised approach is possible, cost effectiveness might. Screening programmes provide a good example of this because individualised assessment to determine who is suitable for screening, or screening everyone,

[21] Note 18, above, at p.217.

would carry significant resource implications. This issue goes to question of justification of dignity harm caused, to which the next section now turns.

Justifying dignity harms

The presence of a dignity harm is of course not the end of the issue. While some accounts of dignity suggest that dignity is inviolable, and thus that no action which results in harm to dignity, or which fail to respect dignity, can be justified, other accounts of dignity imagine dignity as an interest, right or value which may be weighed against others. In many of the cases reviewed in previous chapters (and particularly those invoking Article 8 of the ECHR) harm to dignity was treated as something which could be justified. Potential dignity harms were weighed against other rights and interests including autonomy, the right to life, and the dignity of others. The next section considers whether the justifications which are advanced in relation to the use of age as a proxy in health care allocation are compatible with dignity.

Best interests

It was evident from the survey of age discrimination in chapter two that the use of age as a proxy in determining which health care interventions should be offered is sometimes justified as being in the best interests of the patient. Best interests may be given as a reason for using age as a proxy for, for example, the risk of the success or failure of a particular intervention where it is argued that the use of some other test to determine eligibility would be harmful. It was seen in chapter two that age is used this way in relation to some screening limits in order to avoid the anxiety and further testing associated with false positives or even to avoid the distress of a true positive where the patient is likely to die of other causes before the relevant cancer is problematic. Age was also used as the lower limit for cervical cancer screening to avoid the need to target young sexually active adults with the associated stigma that may create. There was also some evidence that clinicians may be failing to offer certain forms of surgical intervention to the elderly because of their judgment that, due to the chronological age of the patient, it would not be in their interests (and they wouldn't choose) to be subject to invasive procedures with all of the attendant risks.[22]

Such an approach is potentially compatible with conceptions of dignity which stress the need to ensure that individuals are able to lead dignified lives, at least where this is defined objectively rather than by the individual themselves. Certainly the types of distress and

[22] See chapter two at fn 77.

anxiety which the use of age in the above examples is intended to avoid can, arguably, be characterised as examples of harm to dignity. It was seen above, for example, that health conditions or interventions which cause significant psychological or physical distress are argued to harm the dignity interests of the individuals involved. Where, therefore, clinicians judge that offering an intervention to those outside a particular age range may give rise to such effects, and therefore harm the dignity interests of the patient, a decision not to offer treatment for that reason appears to be not merely compatible with but required by this conception of dignity. On the other hand, where views of individual clinicians or of the state as to the best interest of the patient differ from those of the patient themselves, conceptions of dignity which prioritise autonomy suggest the views of the patients should prevail, or at least should play a central part in the decision making process. On this model, dignity may require that, as far as possible, patients are able to choose themselves whether or not to risk the potentially distressing effects of an intervention rather than be protected from these effects by the denial of choice.

A number of examples of 'dignity as constraint' were identified in previous chapters in cases where restrictions on individual autonomy were justified (or argued to be) by the need to protect individuals from situations or choices which risk harming their dignity. Examples of this 'paternalistic' conception of dignity were seen in cases such as *Seldon* where manadatory retirement was justified as a means of protecting older workers from potentially humiliating capability reviews and in *SAS v France* where the government had argued (unsuccessfully on the facts) that the ban was to protect the dignity of those who wore the veil from the dehumanising effects of the 'effacement' from public space this bought about.

The position is of course complicated in the healthcare context by the fact that medical professionals are obliged to act in what they perceive to be the best interests of their patients.[23] They certainly cannot be compelled to act against their own perception of the patient's best interests, nor does a patient have right to any particular treatment (though they may refuse treatment against the advice of their doctor as to what is in their best interests). The difficulty in deciding whether and when patient autonomy should take priority over the professional duties of beneficence and non-maleficence to is one of the central arguments in medical ethics.[24] Within a dignity framework, it represents a clash between what Beyleveld

[23] Herring, J. (2012) *Medical Law and Ethics* (Oxford, OUP)
[24] Beachamp, T.and Childress, J. (2012) *Principles of Biomedical Ethics* (*7th Edition*) (Oxford, OUP).

and Brownsword have characterised as dignity as empowerment and dignity as constraint (where the perception of the clinician or the state as to what dignity requires may trump the autonomy of the patient).

It was seen in chapter six that, although there is no right to any particular medical intervention, a number of recent cases have linked dignity to the need for patients to be informed and to have the opportunity to express their own preferences about potential treatment (or non-treatment) pathways. Thus in *Tracey* the duty to consult with the patient about a decision not to resuscitate, was held by the Court of Appeal to be 'integral to the respect for the dignity of the patient' even where the consultation may give rise to some distress on the part of the patient.[25] The Court did concede that the doctor's duty to involve the patient in making this type of decision did not extend to circumstances where consultation was likely to cause physical or psychological harm to the patient. It was stressed, however, that doctors should be wary of excluding patients from the process through concern that it may distress them. A similar conclusion was reached in *Montgomery* where, again, respect for dignity was said to require the provision of adequate information on the risks of and alternatives to any relevant intervention. Here, again, while the court accepted that a clinician was not required to do so if serious psychological harm would result. However, it was stressed that this exception to the general principle should not be used in order to enable a doctor to prevent the patient making an informed choice to act against what the doctor perceived to be their best interests. It is worth remembering that, consistent with their decision in *Burke*, the Court stressed that the duty to consult should not be confused with an obligation to provide a certain form of treatment. The patient has no right to insist on a particular form of treatment, though they may refuse it. The respect for dignity here lies in the involvement of the patient in the decision and not in the actual provision or refusal of the treatment itself.

On this autonomy focussed account, then, dignity may require patients to be informed of risks and to, as a minimum, participate in a decision as to whether they wish to accept the possibility of a false positive with the anxiety to which this may give rise when balanced against the statistical probability of having the disease based on other relevant factors. If dignity requires information and consultation in all but extreme circumstances, then the use of age to avoid it cannot be justified as being compatible with or required by dignity.

[25] *Tracey v Cambridge University Hospitals NHSTrust* [2014] EWCA Civ 822 at 47.

Efficiency and fairness

In addition to best interests, many uses of age based rationing – in common with all rationing - are justified in relation to the need for the fair and efficient use of scarce health care resources. If resources are finite and scarce then any allocation will always involve a choice between meeting different health care needs. Denial of an intervention to one patient may be necessary to meet the needs of others. Given the close association between dignity and minimum health related quality of life, discussed above, it is difficult to see how such an aim could itself be incompatible with dignity. What will be crucial in relation to this justification is, of course, the weighing of the various interests involved in the context of an analysis of proportionality. This is not something which can be attempted here. However, this final section will comment briefly on a number of points of particular importance to this exercise.

First, it will be remembered that one of the putative roles for dignity was argued to be as a common metric in weighing the different interests at stake in an exercise of proportionality. If dignity is capable of playing this role, as both McCrudden and Foster have suggested it is,[26] then the balancing exercise will require a framing of all of the rights and interests affected by a contested measure as dignity interests, which may then be compared and weighed against each other to find a solution which maximises dignity overall. Of course any such approach needs to contend with the different and sometimes conflicting accounts of what dignity requires which have been evident throughout this discussion. In particular, in the rationing context, the exercise may require a weighing of the immediate and obvious dignity interests of a particular individual against the less immediate and less obvious dignity interests of the wider population. If, on the other hand, dignity does not provide a common metric, then the court is tasked with weighing together the various dignity and non-dignity interests affected by a particular measure and the usual difficulties with commensurability may arise.

Second, as was noted in the introduction and in chapter six that, where resource allocation matters are concerned, courts tend to be unwilling to interfere with decisions of public authorities for reasons of both democratic deference and institutional competence. Where resource allocation is potentially discriminatory it was seen in chapter three that the UK Courts, at least in relation to Article 14 ECHR, will adapt the intensity of their review depending on which characteristic is implicated. It was seen, too, that there is still a lack of

[26] McCrudden, C. (2008) 'Human Dignity and Judicial Interpretation of Human Rights' *European Journal of International Law* 655, 656-6; Foster, C. (2011) *Human Dignity in Bioethics and Law* (Hart, Oxford)

clarity over whether discrimination because of age merits the same intensity or review as does discrimination on grounds of race or sex.

The third point follows directly from this. The dignity harms which uses of age to determine access to resources may cause, identified above, appear to be harms which arise even when a complete life view of equality is taken. If this is true, it is important that courts, in determining the appropriate level of review, and in conducting an analysis of proportionality do not, having themselves adopted a complete life approach to equality, decide at the outset that age is different from other protected characteristics for this reason. If dignity harms arise from the use of age then it is not clear why attempts to justify these harms should be treated as a different exercise from attempts to justify the same dignity harms arising from the use of other characteristics.

It is plausible (though bearing in mind the caveats raised in chapter four) that *some* examples of age based rationing will result in *less* harm that rationing based on other characteristics. One harm which may not arise as a result of age based rationing but which may be present where other characteristics are used is an unequal distribution of health care benefits across a lifetime. A second harm which may also be absent, as a result, is the communication of lesser worth that such an unequal distribution may involve. However, depending on which conception of dignity is at stake, this thesis has sought to demonstrate that age based rationing also has the potential to give rise to dignity harms which are unrelated to unequal lifetime distribution. It may well be, of course, that we accept some of these harms as being necessary in order to secure a distribution of resources that best protects the interests, including the dignity interests, of others or which provides the fairest distribution among the population as a whole. But the point is that where the treatment under question involves harms which cannot be discounted by taking a complete life view of equality, there seems to be no reason why the approach to justifying age discrimination – both the intensity of review undertaken by the courts and the conditions under which the discrimination may be justified - should be different from that for other characteristics.

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